MENTAL HYGIENE

VOL. XXX JANUARY, 1946 No. 1

PROTECTING THE MENTAL HEALTH OF THE VETERAN*

GENERAL OMAR N. BRADLEY

Administrator of Veterans Affairs, Veterans Administration, Washington, D.C.

SEVEN months ago, when American troops were breaking through enemy defenses in the Ruhr, a newspaperman called on me in Germany. He had just completed a three-months trip home and, although still tired, appeared happy to return.

I asked him why. With the end in sight, our men were growing homesick and even the large prisoner bags had lost much of their satisfaction.

He pointed to the road outside. It was almost choked in the movement of tanks and trucks, crowded with American soldiers hurrying toward the front.

"You've got America here," he said. "I had to come back to find it."

To-day that uniformed heart of the nation is coming home for discharge at the rate of almost a million men a month. Although the worse part of the war is behind them in the suffering and deprivations of combat overseas, they face continued dangers in this twilight phase as veterans. Having mustered them from useful jobs, we are committed to the task of returning them in a world that has been changed.

Until these veterans find employment, rebuild their lives, and resume their responsibilities as civilians, the war is not ended and we cannot escape or evade our duties to them.

In this twilight hour of the war, as many of our men have changed, so also has the face of the nation to which they

* Presented at the Thirty-sixth Annual Meeting of The National Committee for Mental Hygiene, New York, November 1, 1945.

are returning. War-time production has in many ways reshaped the structure of the economy they will find. Industrial reconversion, with its relocation of part of the civilian population, creates conditions that are temporary, but none the less perplexing to any one long absent from this domestic scene.

While effecting this shift to a peace-time basis, we must remind ourselves that it is not enough to have won the war by destroying our enemies' armies. To make it meaningful, we must go farther. We are now faced with the necessity of providing the veterans who struggled to win it an opportunity for achievement of their fox-hole dreams.

Never in our history have we been gifted with a greater reservoir of enterprising and talented youth, confident in their ability to achieve great projects in company with one another. Never have we had a greater chance to prove to youth, already conscious of the strength of our democracy, that a government founded in the rights of its people offers the greatest freedom of opportunity.

Veterans, however, are finding some communities already fumbling this chance. Where men have stumbled in disillusionment through lack of home-town counsel, guidance, or concern, they're already growing bitter.

If our people content themselves with good intentions rather than the good works needed to assist and guide these men, we shall not only trample these golden chances, but also dishonor the promises this nation has held out to veterans in everything for which they've fought.

In some ways, the veteran has been more fortunate than others for he has seen the results of the nation's heroic war-time effort. A soldier or sailor, standing on the deck of a ship in the cross-channel invasion of France, could not but feel an unconquerable pride in the people of the country that produced that armada. Whatever fear they felt was the fear men feel for themselves in battle. There was not fear of failure. They were strong in the knowledge of what had been done, confident that with such weapons they could win.

Now with our enemies defeated and with the way cleared to standards of our own making, we find that our millions of home-coming veterans have become millions of anxious job

hunters. And there are those who already echo the fears of joblessness and insecurity.

As job hunters, these veterans should be welcomed home. For, with few exceptions, they are eager young men, ready to contribute skills, talents, and leadership to the creation of still more jobs, the development of industry, and the enrichment of our lives.

Veterans are the vital and youthful hope of this country, bringing imagination and faith in their ability to produce—if only given the chance.

This, gentlemen, is where you come in—you and your neighbors in every community.

For, in protecting the mental health of the veteran, we are first concerned with giving him the chance to become a useful citizen. He must be freed from the specter of jobless insecurity, steered from the hazards of disillusionment that come from a run-around, and protected from the mental and emotional handicaps that retard civilian readjustment.

As a federal agency, the Veterans Administration is a colossal institution. In an effort to carry our multiple services to the doorsteps of all veterans, we may eventually have 120,000 employees. Our hospitals already reach around the nation, and the number is being expanded. Eventually we may write the checks for several million veteran students. Our insurance business is easily the largest in the world.

Altogether, we spend as much in nine months as the atom bomb cost to develop. The veterans who come to us will form a significant part of the country's population. And yet, despite the enormity of these operations, we're only a small part of the picture.

Other Washington agencies also have their veterans' aids, benefits, and privileges. Yet, when you add their parts to ours, you have only a section of the story. For Washington alone can no more solve all of the veterans' problems than Washington alone could win the war. Government can provide the stimulus and guidance; America must do the work.

Unfortunately some people have an idea that the G. I. Bill of Rights is a cure-all remedy for everything a veteran needs. After our tragic experience in previous wars, the G. I. Bill of Rights can properly be termed a forward-stepping provision—granting greater recognition than has ever existed

before to the immediate and eventual needs of veterans. But even the G. I. Bill of Rights is largely a check-book piece of legislation. The ability to make it fully worth while to the veteran is in the hands of each community.

These financial benefits do not seek to compensate the veteran for his duty to the nation. We accept, as a premise of democracy, the duty of its citizens to rally to defense when the nation's life is threatened. In opening its check book, Congress aims essentially to give the veteran a start in the life he left behind.

When the veteran gets home, it is here that he must make the change from soldier or sailor to civilian. Home is the end of the line in the mechanics of demobilization; but it is the beginning of the new life to which the veteran is returned.

Here the veteran discards his uniform and the regimented manner it clothed. Here he ceases to be a statistic and becomes an individual, a neighbor to his neighbors, a man with traits, talents, desires, and interests peculiar to himself.

It is in his community that the veteran rubs shoulders with the civilian attitude that will manifest itself in gratitude or unconcern. Here the good intentions can become the good works. Here he can be welcomed and encouraged as a useful member of his community or neglected and forgotten. Here he can be guided to a job—not just any job, but the right one—or discarded as a problem.

Mind you, the veteran is not a problem, but the community can make him one by not attending to the problems he will meet.

Any short-memoried community—with citizens too busily engaged in their own peace-time planning to give adequate care, counsel, and guidance to their returning veterans—must expect to reckon with the eventual cost of their neglect.

Hundreds of thousands of the young men funneled into service during the early years of the war found it impossible to adjust themselves to the impersonal, unitlike existence of the barracks. Separated from their families, uprooted from routines, denied their social relationships—they found it difficult to fit into the rigorous, unfamiliar schedule of war-time training.

Many were labeled psychoneurotics and promptly dis-

charged from the service. Large numbers of these men were restored to normalcy by separation and have returned to useful occupations. Others, though returned, will require additional medical treatment. And still others were committed to hospitals.

Now, in demobilization, we shall find a reversal of that situation. Many young men will find themselves fully adapted to life in the service, where they have been compelled to submerge their personal lives, desires, and interests for the common good of their comrades. With the end of the war, they are again returned to a competitive society, where it will be necessary for them to readjust themselves.

It is in this period of readjustment that the community—together with federal and state agencies—must be prepared to give its aid in jobs, educational counsel, vocational training, financial rearrangements, housing, and honest, neighborly advice in the host of personal problems with which the veteran is confronted.

Failure of the veteran to secure such ready assistance can result in bitterness, resentment, or frustration. When that happens, the community has not only lost the services of a valuable citizen, but at the same time it has created a condition that can breed a psychoneurotic.

I am not suggesting that every veteran, dissatisfied with the treatment in his home town or disgusted with the delays of officialdom, will then become psychoneurotic. Most of them would get along somehow by themselves. But with 15,000,000 men in the services, even the numbers of those with psychoneurotic tendencies could become proportionately large.

Between the first World War and this one, the Veterans Administration has had 375,000 admissions to its neuropsychiatric hospitals—the great majority of them resulting from non-service-connected cases. Many of these can be presumed to have resulted from the failure of veterans to become properly readjusted to civilian life at the end of the last war. In that generation, the government has paid out approximately one billion dollars for the care, treatment, and compensation of World War I veterans with neuropsychiatric disabilities.

Of course, not all veterans are going to want or to need

help, either from their communities or the government, in reëstablishing themselves. Some are so permanently fixed in their professions or careers that they can pick up the loose ends with little outside aid.

Veterans who came to the service, however, directly from high school or college are in a markedly opposite classification. They will need sympathetic guidance and counsel, schooled to their wants, and prepared to help them on important decisions, vital to their futures.

There is still another group of veterans to whom the community can provide an important aid. This group includes those men who are anxious to make a change from their pre-war patterns of living. Statisticians are already concerned over the great number of veterans from this war who have indicated their unwillingness to return to their pre-Pearl Harbor jobs. I say it's a good thing. For the first time, many of these men—with the aid of veterans' benefits—have been able to break clear of earlier binding vocational ties and now find themselves free to pick careers of their own choosing.

It is these men who will benefit most in that phase of demobilization of which President James B. Conant of Harvard recently wrote, "The demobilization of our armed forces is a God-given moment for reintroducing the American concept of a fluid society. If it is handled properly, we can insure a healthy body politic for at least a generation. Handle it improperly, and we may well sow the seed of civil war within a decade."

In cities and towns where community service centers work, the task of the federal government can be accomplished with greater benefit to the local veteran. And in communities where such centers are less effectual, the G. I. is the loser and government aid is not fully and usefully employed.

I know of nothing more important to the veteran than a sound community center to which he can take his problems. Self-help at the local level is the only way veterans can be provided the sympathetic counsel needed on their return.

The point I am trying to make is this—right now we have an opportunity to reduce the number of neuropsychiatric cases we may have several years from now. If we are able

properly to refit our veterans into their places in civilian society, we shall have, generally speaking, a mentally healthy group. If we fail in this, we have many who may be mentally confused and may become prospective patients.

I believe that this danger can be reduced if communities will make this their problem and solve it by means of properly run community centers.

There are many well-run veterans' centers with which I am familiar. Their patterns are quite similar and no doubt exist with minor discrepancies among others throughout the country.

Representative organizations of the community are invited to pool their resources in the establishment of one center. This center then becomes an actual service center as well as an efficient reference unit with a friendly local follow-up. Coördination eliminates the danger of duplication and avoids confusing competition among the well-intended local agencies. More important still, it lumps all services for the veteran in a single place.

I need not remind you that the veteran cannot be given the run-around, sloughed off, or parked in a dark corner to be forgotten. This time there are too many.

Where the Veterans Administration is invited to participate in community veterans' centers, we shall respond gladly and assist in any way we can.

This is no more than a reiteration of our policy of decentralization—the carrying of our services out of Washington to the doorstep of the veteran.

In conclusion, I should like to say a few words about the medical program of the Veterans Administration, partly to acquaint you with what has been done, partly to ask you for your help.

We are convinced that the American medical community must be asked to share in our great work, to draw on the talents of outside physicians to supplement our own.

We are convinced that out-patient treatment must be extended and staffed with competent part-time doctors.

We are convinced that veterans' hospitals must draw upon the learning and ingenuity of the teaching staffs of university medical schools.

We are convinced that teaching practices must be carried into our veterans' hospitals with the establishment of consultants and resident physicians.

We are convinced that specialization must be encouraged and developed.

We are convinced that veterans' hospitals must be located nearer doctors, that larger institutions must be established near the teaching centers.

We are convinced that research must be developed and expanded to keep our practice modern.

We are convinced that we must pace the development of artificial limbs by sustaining and supporting research.

We are convinced of the need for rehabilitation through modern and continuing occupational therapy.

And we are convinced of the need for establishment of our own medical corps.

Definite and encouraging progress has been made in each of these fields. Everywhere the medical profession has responded enthusiastically to our plans.

In the execution of this program, we may sometimes make mistakes. Those mistakes, however, will be honest ones. We give ground to no one in our determination to do the job as these young men will certainly want it done.

I am certain you will be with us.

MOTION PICTURES AS A MEDIUM OF EDUCATION *

LIEUTENANT COMMANDER HOWARD P. ROME (M.C.), U. S. N. R.
Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

LARGE-SCALE public education—which is mental hygiene in its broadest sense—is the order of an atomic age that threatens to pit man against man in the race between civilization and disaster. It seems pitifully anachronistic to pour energy and resources into static defenses which are likely to be to-morrow's outdated Maginot Lines. In an atomic age, defense and offense are strategically synonymous and if, in the words of General Marshall, we are to avoid carrying the treasure and the freedom of our nation in a paper bag, we must effectively employ the tactics of extensive education in the principles of human relations.

Among the remote repercussions of the explosions at Nagasaki and Hiroshima is the feeling that has been expressed by Professor Henry Smyth, author of the war department's principal report on the atomic bomb:

> "If men, working together, can solve the mysteries of the universe, they can also solve the problem of human relations on this planet. Not only in science, but now in all human relations, we must work together with free minds."

The discrepancy between this desire and its attainment is the more striking when the reasonableness of the goal is posed against the complexity of the task. The first step toward bridging this gap calls for an assessment of present methods of education in human relations.

With due allowance made for imperfections, are present and potential educational resources able to provide the ways

* Presented as part of the program of the Thirty-sixth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 1, 1945.

The opinions contained herein are the personal ones of the author and should not be construed as official or as reflecting the views of the navy department or the naval service at large.

and means of teaching the technique of harmonious living? If it is admitted that, within inherent limitations, such educational accomplishments are possible, what is the strategic approach? Furthermore, what tactics shall be employed, and are there any clues deserving of a more intensive investigation?

We, as psychiatrists, mental hygienists, and social scientists, are the educators upon whom devolves a large part of this teaching responsibility. The grist of our mill is human behavior as it occurs normally and pathologically in individuals and in groups. The clinical experience that we have acquired in the war wholly corroborates John Dewey's contention that the teaching of democracy must begin at home, and home is the neighborly community. What has been lacking up to now has been an adequate large-scale method of communicating such knowledge as we have had. Too often John Q. Public has been held responsible for acts of commission that in reality are more properly attributable to his teachers' acts of omission. Aside from the tremendous and powerful intrapersonal forces which we have admitted influence his motivation, his attitudes, and his behavior, we must also admit that there are turbulent interpersonal forces that also grip him. These, too, are enormously potent. The past three and a half years have taught us full well their capacity viciously to distort his, as well as his group's, destinies. As Gordon Allport has pointed out, increasingly since the days of the Industrial Revolution, individuals have found themselves struggling with issues whose workings they have no power of comprehending, much less influencing.

Recognizing the complexity of modern society, educators such as we cannot permit the thread of common understanding, which can tie man to his fellow men and which can bind groups together, to be lost in the labyrinth of isolationism. Such education as psychiatry and most of the social sciences have to offer may at first glance seem like a fragile thread upon which to hang man's hope. Now is the time of decision. Henceforth education can lead a bachelor existence in ivory-tower pedantry, or it can wed itself to younger techniques and set itself to the natural task of raising the level of human relations. Paradoxically, the war has stimulated a gratifying interest in the latter course.

The enthusiastic employment of audio-visual techniques by the federal and state governments, the armed forces, and industry has helped accomplish the most phenomenal large-scale training and preparation in history. In order to do this, the war and navy departments have become the largest motion-picture producers in the world. The war department's budget for films alone has been roughly estimated to be 50 million dollars annually. The navy, in three and a half years, produced 3,500 training films averaging two reels each. During the same period, it made some 2,200 film strips. It has been estimated that the United Nations have distributed films on some 20,000 different subjects to its armed forces ashore and afloat.

The gamut of subjects presented by these films is equally impressive. The navy, for instance, learned early that cameras are guns and pictures are bullets. From black-and-white live-action films to animated motion pictures in color and sound strips, the jobs of training in telephone talking, in look-out recognition, in the making of hospital beds, and in the repair of radar equipment have been presented to the navy's four million officers and men. These films have earned their well-done commendation. They taught civilian novices to be experts in the most specialized branch of the armed forces, and a similar job has been done by the army, the air forces, the Coast Guard, the Merchant Marine, and the war industries. Now is the time of our reconversion; now is the time for these war-built weapons to be turned to use as the ploughshares of an enduring peace.

The successful prosecution of a global war and, by the same token, the accomplishment of a global peace, take know-how—the tactics of military operations. Tactics are the ways and means of converting strategy into action. The final link is logistics. Nathan Bedford Forrest, of Civil War fame, simplified this formula of supply for the demands of victory by explaining that wars were won by those who got there "fustest with the mostest." If educators are to be successful in the most crucial task in history, they will have to adopt similar logistics. Motion pictures can be made a weapon that can carry their ideas. Their worth has been proved in the war for men's minds. And there are many

tactical maneuvers of psychological warfare that can be profitably reconverted to peace-time use.

The war background of films on ideas and attitudes and motivations—what the services have called "orientation"—is of practical interest for educators. Like other instruments of power, motion pictures are equally capable of building and of destroying. During the parlous times of the latter thirties and the early forties, as each new stage of conquest was being set by divide-and-conquer tactics for the blitzkrieg that was to come, the Nazis said it with pictures. A film they produced called *Triumph of the Will* is a typical example. It was designed not only to build the morale of the Herrenvolk, but also to be shown to non-German audiences as a first wave in a series of emotional offenses. These were the methods that contributed to the debacle at Munich and later neutralized the Maginot Line.

It was with classical Goebbelesque finesse that pagan Nuremburg rites were filmed by torchlight and cameras trucked for hundreds of yards past spectacular military demonstrations. *Triumph of the Will* counterposed dramatized man power against sentimentalized Hitlerean paternalism. It presented destructive military resources in contrast with scenes of filial allegiance. The *Führer* and his *Gauleiters* were repeatedly shown receiving flowers from smiling and glistening country children and plaudits from their elders. Interposed between these bucolic tributes were significant long-angle shots of row after row of grim-faced S. S. men. *Triumph of the Will* was made to leave little doubt that it was an advance notice of a show to come—particularly when its foreign audiences knew that they had reserved seats for a command performance.

We and our allies fought a different kind of film war. One can get some idea of its magnitude when it is realized that 300 million feet of film in the possession of agencies of the United States Government became non-current on V-J Day. The strategy of our film war has been education. Its tactics have been twofold: first, to develop training methods to teach more people in a better manner more quickly; and second, to provide a continuous source of truthful information. For instance, over 100 films have been edited and scored in Chinese. The Office of Inter-American

Affairs has made it possible for sixteen million Latin-Americans to see newsreels each week. Sixty-six medical films for specialists have been adopted for use in Central and South America. The navy and army industrial-incentive divisions have developed "smoke-stack circuits." The navy alone estimates its industrial audience to have been one and a half million people per month. The *Army-Navy Screen Magazine,* a two-reel weekly made by the army pictorial service, had a world-wide distribution. It told the G.I., in his own language and in his own way of looking at the news, what was going on in the world. You must have seen Snafu, the feature cartoon character, to appreciate the subtlety and the craftsmanship that were used equally successfully to sell the idea of V-Mail and to disseminate information about malaria.

The documentary films that have been produced are the dynamic models of a new kind of visual education which can show equally well a simple event or the panorama of history. From 1943 until its termination, O.W.I.'s overseas branch made 26 documentaries designed to give foreign audiences a true picture of American life. The series called *The American Scene,* which included *Swedes in America, The Valley of the Tennessee,* and *Arturo Toscanini,* are classics in the field of intergroup relationships. *The True Glory,* an official United States-British film of the epic campaign that began at Southampton and ended in Berlin, is the war's outstanding example of documentary pictorial history, made from some six and one-half million feet of film. It cost the lives of 32 United Nations combat cameramen; 101 more were wounded in their attempt to tell the story of one phase of democratic teamwork. The narrative device of using the voices of the men and women who made the history to tell it as they saw it successfully bridges the usual gaps of time, place, and person.

The relations between war, men, and geography also have been told in this new way in the British film, *Desert Victory,* the story of El Alamein and the 8th Army's advance across the desert to Tripoli. *With the Marines at Tarawa,* and *The Battle for the Marianas* are part of the same text, which began in 1941 with the R.A.F.'s Academy Award winner, *Target for To-night.*

In the field of mental hygiene and psychiatry there had been some attempts to use motion pictures even before the war. Various special methods and techniques have been employed in this field and footage from recreational films has been used as pictorial illustrations.

The Human Relations Series of films, prepared by the Commission on Human Relations of the Progressive Education Association, have made an important contribution to the technique and philosophy of education. The manner in which these films have been used, to stimulate free discussion and foster spontaneous and independent thinking, is of fundamental importance in the education of psychologically free people. This kind of teaching is not only educational in an informational sense—it is also prophylactic in a mental-hygiene sense. For it takes heed of Alexander Pope's advice that the proper study of mankind is man. Dr. Alice Keliher's personal contributions in this field of motion-picture education have been a pioneer venture of paramount importance. Her use of films and footage from commercial pictures has developed a brand-new type of textbook in the problems of interpersonal relationships. Education of this sort is basic to the teaching and appreciation of democracy.

It is vital in the planning of a program of this scope to remember that education, like medicine, does not have to be bitter and unpleasant to be effective. It is indeed fortunate that there is a vehicle that can convey these benefits in a manner wholeheartedly accepted and easily understood by every one. It has been scientifically verified by opinion polls conducted in the armed services that films are the favorite off-duty activity of one enlisted man out of every four in the United States. Apropos of the educational potentialities that this offers, the special services division of the army service forces undertook a measurement of the effectiveness of informational motion pictures. The classified status of these data has been withdrawn and the results of this valuable compilation may now be made public.

The orientation-film series called *Why We Fight* and the bi-weekly feature, *The War Department Report,* were used as test objects of one typical survey. Two basic factors were measured: (1) the gains in factual information, and (2) the changes in attitudes related to the principles for which we

were fighting. Incidentally, there are six films in the *Why We Fight* series. The titles themselves are illustrative of the texts: *Prelude to War, The Nazis Strike, Divide and Conquer, Battle of Britain, The Battle of Russia,* and *The Battle of China. The War Department Report* grew to be a collection of some 56 films, of an average length of 10–15 minutes.

An analysis of the opinion polls based upon two sets of groups of men, one made up of those who had seen the film and the other of those who had not, indicated that of the groups to whom films had been shown 18 per cent more men on an average were able to answer relevant questions on historical facts. As far as the films' capacity to influence attitudes, in every instance this was statistically demonstrated. For example, the film *Prelude to War* depicts vividly Nazi oppression and persecution of religion. Seeing the picture, as opposed to depending on the usual sources of opinion formation, convinced 8 per cent more men of the groups who were questioned that the Nazis would abolish freedom of religion in America if they won the war.

After the film, *Battle of Britain,* which stressed Churchill's classic statement in praise of the R.A.F.—"Never . . . was so much owed by so many to so few"—74 per cent of the men who had seen the film agreed that the R.A.F. was the most important factor in saving England. In contrast to this, only 45 per cent of those who had not seen the film had the same attitude. This ability to mold attitudes in a significant percentage of instances, as indicated by this same study, is attributable in a large measure to the appeal of the film. For example, when the film was liked, 16 per cent of the answers were favorably influenced; when the film was not liked, only 6 per cent changed their opinions.

This same group of army investigators developed a program analyzer, an electrical device to measure audience interest. Each member of an audience that is to be polled is given a panel of two buttons, marked "like" and "dislike" respectively. They are told that they can indicate the parts of the film that they like by pushing the button marked "like." Conversely, if they dislike a certain part, they can say so by pushing the button marked "dislike." Further, it is made clear to them that they can indicate their pleasure

or displeasure as often as every six seconds. The recording device is so constructed that the collective impressions of an audience can be tallied and recorded at six-second intervals.

From studies that have been made, it has been shown that there is considerably more audience interest in scenes illustrative of narration than there is in shots of the narrator telling his story. This is the electrical-age proof of the old Chinese aphorism: "Hundreds heard not like one see." It is also proof of our own adage: "Seeing is believing." This type of film analysis provides many clues not only for the actual construction of future pictures, but also for the method of their use. For example, there is considerable evidence in the teaching of psychiatry that there is much less student interest and consequently much less profit in the didactic lecture than there is in a clinical presentation or a group discussion or a motion-picture demonstration.

As a concrete application of the usefulness of motion pictures in education, the series of films that have been produced by the navy department for use in the naval group-psychotherapy program are a pertinent illustration.

Like other kinds of education, group psychotherapy has as its goal the employment of certain technics to communicate facts, to mold attitudes, and to influence behavior. It has further goals, for it attempts not only to make the benefits of psychiatry available to a number of people simultaneously, but also to use the social environment of the group itself as a therapeutic tool.

It is one of the convictions of this type of education that the opposition that has frustrated the well-intentioned efforts of psychotherapists and mental hygienists cannot be entirely ascribed to "emotional resistance," as most psychiatrists narrowly define the term. For one thing, there is a purely semantic difficulty which is often created by the tedious and cryptic verbal formulations that have saddled psychiatric doctrine from its inception. In addition, there is the factor of audience interest which has to do with the attention and the empathy of the listening group. As educators are only too well aware from personal experience, the psychological "set" of the situation through which psychotherapy—or, for that matter, educational efforts or even a political speech—

has to be filtered before it accomplishes its purpose, can either immortalize it as a blood-sweat-and-tears utterance or consign it to the limbo of the millions of words that have been cried in the wilderness.

The use of properly made audio-visual aids materially eliminates this difficulty. They can set a psychological stage by quickly creating a receptive emotional tone. Once this is accomplished, the psychotherapist or the educator can proceed to elicit from his group whatever appropriate patterns of adaptive or projective behavior he has as his therapeutic goal.

This was the hypothesis that prompted the bureau of medicine and surgery in 1943 to undertake the production of a series of motion pictures for use in the psychiatric treatment program. Primarily, the films were made to supplement the group-psychotherapy program in the general and special naval hospitals. In addition, they have been used as training aids for nurses, hospital corpsmen, and medical officers. Third, they have a use in a prophylactic and educational curriculum for non-psychiatrists. Finally, on a limited experimental basis, they have been used as projective and diagnostic screening tests, as well as to condition and decondition psychiatric patients.

Direct observation of the group, individual personal interviews, and a questionnaire poll have been used to gauge the effect and potency of this therapeutic instrument. Experiments in infra-red audience photography during the presentation of these psychiatric films, as well as recordings of the discussions that followed, have been valuable pilot studies. Only by this type of control can both subjective and objective documentation of patient response to motion pictures be secured. It is hoped that ultimately these data will help establish a scientific frame of reference for psychiatric motion-picture education.

In summary, the medical department's experience with these eight films have covered a period of almost three years. Individual-interview and questionnaire responses from several thousand patients have been assembled and these data attest the value of the films.

Seventy-five per cent of the selected psychiatric patients who have seen one or more of these films have experienced

various psychosomatic reactions—nausea, tremors, palpitation, sweating, and the like. These vary in intensity, depending upon the patient's preparation. In a controlled degree such response is helpful, provided the therapy that follows utilizes the opportunity as an occasion to personalize and socialize the response.

Eighty-six per cent state that seeing the films vividly reminds them of their own battle experiences. In this connection it should be noted that this is a clear index of the patients' capacity to identify with generic experiences. For instance, of the group who have seen the film, *Introduction to Combat Fatigue,* and recalled their own battle experiences, only 30 per cent had actually participated in the kind of jungle warfare that is the theme and setting of the film. A further proof of this is to be had in the statements made by the 70 per cent who admit identification with the characters and the events portrayed. Seventy-six per cent of the patients said they felt that seeing the picture enabled them to understand more clearly the nature of their own emotional disturbance.

The films have an emotional effect that lasts for some time; 45 per cent of the patients, according to their own statements and documented observation, continued to be aroused for two days after the first showing of the film. This undercarriage of tension can be used to accomplish a beneficial abreaction either in group therapy or in individual therapeutic session.

It has been our experience that the judicious use of these films not only has brought about a better type of group psychiatric treatment for certain types of patient, but also has sharply reduced the time necessary for their treatment.

The implications that films such as these have for psychiatric education are manifold. The imaginative use of the camera can recreate dynamically the background, setting, and formulation of typical individual and group problems. In this objective way, the bases of motivation, attitude formation, and behavior can be presented strikingly to many groups of persons. Moreover, a presentation of this sort can be worked over and polished so that every word and every action are goal directed. What is said and shown is both precise and definite. Further, psychiatric films can be vali-

dated by scientific methods for standardized use on a larger series of patients than can any comparably controlled clinical psychiatric procedure.

The drama and dynamics of psycho-social relationships lend themselves to cinematic portrayal with a realistic flexibility that has very few limitations. In all cultures and in all times, the theater has been a mirror in which man and his society have seen themselves objectively. It does not stretch genetics for motion pictures to claim kinship with drama. And the relationship of psychiatry to the theater and the motion-picture art is equally close.

A therapeutic film has to be conceived and produced in a manner quite different from the usual recreational or entertainment film. Psychiatric treatment films are not ends in themselves. The emotional response they evoke has to be capable of being turned to psychotherapeutic profit. Good films, like other good educational devices, ask questions and do not retail prefabricated answers. Good films are adjuncts and supplements to psychotherapy. They are not the panacea, the royal road to learning, or the spurious prophet heralding the coming of a get-wise-quick era.

The therapeutic film has to have the capacity to provoke an emotional reliving of personal experience. In order to accomplish this successfully, the theme has to have generic validity and the ability to stimulate the audience to specify their response in personal terms. The sequence of events has to be presented synoptically. Literal chronology and the boring detailing of irrelevant facts must be avoided. By innuendo and implication, the confusing and the inessential can be subsumed in a backdrop of action. Camera, editing, and cutting techniques can be utilized to high-light important events. Various other standardized motion-picture devices can link effectively the chain of psychiatrically significant cause-and-effect relationships. The addition of a sound track brings into play another wide range of intrinsic resources. Psychiatric films are medicinal; therefore, they have to be compounded and prescribed with the same care as are biological and chemical drugs.

A word about cost, which is not an inconsiderable item. The standard black-and-white live-action film costs on an average from five to twenty thousand dollars. The cost of

prints for the purpose of wide distribution and individual use is relatively negligible. Happily the day is not far distant when the establishment of a national film library or some similar kind of central bureau will provide an accessible correlating agency. Certainly educational and training films of every variety will be listed. It is imperative that some such organization be created to do the over-all administrative work and to advise with groups whose special problems require research and development.

The Commission on Motion Pictures in Education in a recent publication indicated that, although the educational possibilities of motion pictures had been foreseen, the cultural lag between the invention of a new tool and its full use was apparent. In 1940 they estimated that not more than 10 per cent of the schools and colleges in the United States were equipped with motion-picture projectors. The state of affairs in mental-hygiene education is even more laggard. There is a herculean job to be done and full use has to be made of all available resources. The late President Roosevelt in a letter to Dr. Vannevar Bush spoke for the world when he said:

"New frontiers of the mind are before us, and if they are pioneered with the same vision, boldness, and drive with which we have waged this war, we can create a fuller and more fruitful employment and a fuller and more fruitful life."

NEW EVALUATIVE METHODS AND FUTURE PROSPECTS *

WILLIAM A. HUNT, COMMANDER H(S) U.S.N.R.
Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

IN discussing evaluative methods, I shall limit myself to the field of psychological tests, although the trends to be discussed within this field seem to me to be demonstrable in other evaluative methods, such as the psychiatric interview and the social history. For better or worse, the war has dominated the testing picture for the last five years. I do not mean that activity has been limited to military circles. Civilian clinical psychologists have been productive, and without their contribution the military problems could never have been solved. The effort has been a truly coöperative one. I am merely saying that in our military emergency, the needs of a nation at war rightly have dominated the thinking and activity of our professional people.

The result has been adaptation rather than innovation. There has been little time for free investigation. Our efforts have been spent in improving existing techniques rather than in devising new ones. Fortunately, psychological testing had come of age between the two wars, and we were possessed of excellent instruments which could be altered to meet the special problems arising in the services.

These special problems concerned the rapid processing of large numbers of subjects drawn from every social, economic, and geographical section of our population. From their solution have come two important lessons for us: (1) it has been possible to devise more economical instruments than were previously available, and to use them more effi-

* Presented as part of the program of the Thirty-sixth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 1, 1945.

The opinions contained herein are the personal ones of the author and should not be construed as official or as reflecting the views of the navy department or the naval service at large.

ciently; and (2) any standardized, objective group technique has its limitations when applied to the evaluation of a specific individual.

Nowhere have these two lessons been more evident than in the field of intelligence testing. For years individual intelligence tests—tests like the Stanford-Binet and the Wechsler-Bellevue which are given to a single individual in a face-to-face situation—have been laborious and time-consuming both to administer and to interpret. Working at the leisurely pace of civilian life, it seldom occurred to psychologists that the labor involved in these techniques could be lessened. Some effort had been expended toward devising reliable, but brief tests—and I am thinking particularly of the efforts of Grace Kent, with her emergency test, and the attempts of Rabin to abbreviate the Wechsler-Bellevue—but this work went on outside of the main stream of clinical interest.

With the advent of the war, however, it became necessary to devise abbreviated techniques in order to handle the tremendous number of men to be tested within the time limits allowed. The result was an increasing interest in short test forms and the construction of numerous such abbreviated test techniques whose performance compared very favorably with that of the longer tests. The most popular of these have been the Kent Revised Oral Emergency Test, which has been reduced to only ten items, and the C.A.S. abbreviation of the Wechsler-Bellevue, which consists of the comprehension, arithmetic, and similarities sub-tests from the total scale. Many others also have been tried and found suitable.

The correlation between the results on the short forms of these tests and the longer forms with which they have been compared show coefficients within a range that would be considered highly acceptable for the agreement between two different intelligence tests. Because of the short form of the tests, their reliability has not as yet been adequately determined, but there is no reason to assume that it will not be satisfactory. As a result, it is now possible to obtain an objective measure of intelligence in from one-quarter to one-third the time previously necessary.

While such shorter test forms by definition do not offer the complete material available on a longer form, there is

no reason to assume that they are not adequate for many of the purposes of clinical testing. Originally adopted in the mass situations of training-station screening, these abbreviated tests have proven valuable in naval hospitals and disciplinary clinics.

As a result of the wide diversity of material that we have had to handle in the military services, clinical psychologists have become more and more aware of the limitations of our present intelligence tests. Most of our tests have been validated upon large groups taken from urban school populations and, therefore, not representative of the true cultural divergency that exists within the total population. Moreover, the statistical methods involved in test construction are group methods, and the measures that result are in a genuine and peculiar sense group measures. The validity and reliability of such tests, when used as group measures, may diminish or even disappear when they are applied to a single individual.

This is merely another way of saying that any test measure involves a probable error—an error that is small in relation to the group, but that may loom exceedingly large in its importance when a single individual is being evaluated. Thus we know that an intelligence quotient of 60 on the Wechsler-Bellevue implies mental deficiency, but it may also signify the presence of illiteracy, cultural handicap, mental illness, or a behavior problem. The test itself cannot choose between these alternatives. The decision has to be made by the clinical psychologist.

It is necessary for us to remember that by very definition the subject being treated in a clinic is a deviant and, therefore, can be expected to fall outside that "normal" or central group tendency which determines the norms of test performance. In such cases the so-called objective measure rendered by the test is not a valid measure and needs extensive interpretation by a clinician who can evaluate it in the light of the individual's total personality and history.

The field of personality testing shows the same trends found in intelligence testing. The work on the Rorschach ink-blot test is a nice illustration. A great deal of effort has been expended on the Rorschach during the last few years in the development of group techniques in an attempt to evolve a less time-consuming method of administration and

interpretation. Previous interest in such group techniques was largely dictated by the professional desire to make the Rorschach an objective rather than a subjective technique. With the advent of war, however, there was added to this motivation the simple need to cut down, if possible, the amount of time involved in such projective testing. Actually, group techniques have been worked out and have resulted in a greater efficiency in administration. On the interpretative side, however, the attempts to standardize and render objective the interpretation of the individual's responses has met with less success. As studies have accumulated, Rorschach scoring has become increasingly objective, but nothing approaching the objectivity of the scoring stencil of the standard paper-and-pencil test is possible.

A noble attempt in this direction has been made by Harrower-Erickson with her multiple-choice group Rorschach test, in which a group technique of administration has been added to a multiple-choice response situation in which the individual selects one of ten suggested alternative responses to each blot. These responses are then scored automatically right or wrong according to a predetermined standard. Despite the high hopes that attended the introduction of this test, subsequent studies have not shown it to be successful. The very need for such a technique, however, is evidenced by the fact that, despite any body of objective evidence for its serviceability in the situations for which it has been proposed, the test continues to be used.

At present we must face the fact that in the use of the Rorschach we have no substitute for experience and clinical training on the part of the clinician interpreting the record. Here, again, subjective interpretation, clinical intuition, call it what you will, has proved to be a valuable and necessary skill of every clinician. A nice example from the military service can be seen in the objective similarity between the Rorschach records of some severe psychoneurotics and malingerers. Objectively, there may be little to choose between the records of the two; the ultimate decision must be that of the clinician and not of the test.

The same situation is found in the field of screen testing, in which various neurotic inventories have been adapted to the detection of those individuals unfit for military service.

Here, again, it has been possible to devise procedures much shorter than any previously in use, but while such procedures will succeed in picking up most of the unfit individuals in a group, they also pick up a large number of false-positives, or fit individuals incorrectly identified as unfit. Once more it is the clinician, on the basis of further interviewing, who must sort out the sheep from the goats and correct the error of the test.

Such tests are based largely on the uncovering of neuropsychiatric symptomatology, and increasingly we have had to realize that in the military services symptomatology is not equivalent to military disability. Some neurotics will adjust, particularly if placed in favorable circumstances. This implies that in the evaluation of any case we must go beyond the limited objective judgment of the test and obtain an evaluation of the total situation involved. For such purposes there is no substitute for the human mind. A test cannot think, but a clinical psychologist can.

The examples that I have just given you indicate that we can shorten our testing techniques, that much of what we were doing in pre-war practice consisted of overtesting, and that there is a real opportunity for modernizing and streamlining our methods of processing clinical material. They also show us that, despite the brave goals of psychometrics, true objectivity is far from having been attained. There is still a vital need for subjective interpretation within the field of psychological testing.

In discussing the future prospects of evaluative techniques, I should like to point out the influence that I feel these two lessons will have. Before doing this, I shall digress for a few moments and discuss briefly the future of the so-called screen tests or neuropsychiatric inventories, which have had such wide use in the military services. Any number of such tests have been devised, of which the Cornell Selectee Index, developed by Mittelman, Wolf, Wexler, Weider, and their colleagues, and the personal-inventory test developed by Shipley are outstanding. These tests have made it possible, through the use of a simple paper-and-pencil technique, to screen out from any group tested from 80 to 90 per cent of those individuals who are unfit for military service, with a false-positive rate varying from 5 to 20 per cent.

The use of such tests as a preliminary sieve through which personnel can be filtered has lightened tremendously the burden placed upon the military psychiatrist. Their success has encouraged many civilians to hope that they can be applied to civilian selection situations in industry, in court, and in the school system. It is my personal opinion that these hopes are false and that the various military inventories will not lend themselves to civilian situations.

The reasons for this are two. In the first place, these are largely tests for the detection of psychiatric symptomatology, and within the military services there is a much closer relationship between symptomatology and disability than there is in civilian life. As instances of this I might mention enuresis, somnambulism, drug addiction, mild psychosis, and severe psychoneurosis, all of which are automatically disqualifying within the military service, but none of which need necessarily preclude acceptable social adjustment in civilian life. In the second place, such inventories, when used within the military service, are given under exceedingly favorable circumstances, with the full weight of military authority behind them. Individuals taking these tests are universally under compulsion to tell the truth, as the penalties for lying in a military situation are severe. In civilian circumstances, however, I am afraid that these tests, which are so open in their intent and so easily understood by the subject, would encourage falsification and distortion of the true personality picture. For these reasons I feel that we should not expect our screen tests to be adaptable for civilian use, at least not with the same success that has attended their use in the military service.

Let me now return to the discussion of future prospects and, instead of discussing what types of test might be devised in the future, concentrate upon the broader matter of the influence of the two lessons I have mentioned above.

In the past, psychological tests have developed within a theoretical framework fashioned largely by scholarly interests. Testing developed in an academic vacuum, at least a partial vacuum, for it is true that the system leaked a bit at the corners due to the demands of our public-school system. We have not been completely oblivious of practical demands. In general, however, we have fashioned our tests to an ideal

pattern. Just as the development of American literature has been hindered by the burden of the quest for the Great American Novel, so psychological testing has been ridden by the concept of the Perfect Test.

In the military services, however, we have had to throw overboard the absolute concept of the perfect test and substitute a concept of relative value. We have sought the useful test which could contribute to the demands of a practical situation. We have not been after the ideal of perfect prediction. Rather, we have sought for tests that would aid us in improving military selection and educational placement. Thus the fact that the screen tests in use in military selection have a high false-positive rate and are not perfect tests *per se* has not blinded us to the fact that they were extremely valuable in lightening the load placed upon the psychiatric examiner. Moreover, we have had to meet economic factors of cost, ease of administration, time, and man power that are seldom heeded in the academic approach to testing. In civilian practice, when our standard testing techniques allowed only so many cases to be handled, then those cases were all that were handled. The testing load was adapted to the instruments at hand rather than vice versa. In the military services, however, we were given a problem to handle and it was necessary to adjust our test techniques to the task of handling it. The volume of work was given; it was our procedures that had to be adjusted.

As a result, we have devised abbreviated techniques, and also have been careful in the selection of the tests to be given. The older idea of automatically subjecting every patient to a complete battery of intelligence and personality tests had been dropped. Only necessary tests are given. We have had to learn economy of effort. As an example of this, let me point out that where intelligence level enters as a secondary determinant in a psychiatric problem, the measure achieved by an abbreviated intelligence test is often as reliable and contributes just as much to the understanding of the case as would a detailed and complete testing.

From my own experience, I think of one case in which it has always seemed to me that a one-response Rorschach was sufficient to give the psychiatrist the diagnostic assistance he was asking. It occurred with a gentleman who picked

up the first ink blot and said, "The spirit of American democracy typified by the White House with the lawn running down in front of it." Here is the tendency of the schizophrenic to respond with formalized stereotypes and to allow his responses to run completely away from the objective material presented in the ink blot. It is perhaps unorthodox, but in this particular case, where diagnosis alone was in question, there seemed no reason to carry the Rorschach further. This is not to say that every case can be handled as briefly. Obviously, it depends upon the complexity of the case and whether diagnosis alone is aimed at or a complete understanding of the dynamics of the personality as a preliminary step toward psychotherapy. In general, however, we test too much by habit and custom. Much of the testing that goes on at present in our clinics is overtesting and could well be eliminated if the principle of efficiency were introduced in processing patients.

Some such streamlining is going to be necessary if our clinics are to meet the increased demands upon their facilities that is beginning now and that will be greater with the return of all our military veterans. Not that the war has created overly many psychiatric problems. An examination of military statistics will show that the great majority of neuropsychiatric discharges are for illnesses that existed prior to entry in the military service. In such cases the war has not created a problem, but has merely uncovered an already existing one. Nevertheless, many maladjusted individuals have been revealed, and with the popular sensitization to the psychiatric problem that has resulted from the publicity given it in the press, there will be an increased demand that clinical facilities be provided for treatment.

Unfortunately, this increase in the demands upon our mental-hygiene clinics will coincide with a shortage of clinical personnel. We have heard much about the future shortage of medical men that will result from our shortsighted manpower policies during this past war. Little has been said about the shortage in other related fields such as clinical psychology, but the policy here has been even more shortsighted than it has in the medical field. There has been no provision for the professional training of young psy-

chologists, and had the war continued much longer, there is serious doubt as to whether or not the demands of the military services for such personnel could have been met. An increase in the demands for clinical service coinciding with a decrease in the available personnel gives us a situation that can be met only by the streamlining of our present clinical practices. Here we will have to copy from the military services.

The tremendous development of statistical techniques after the last war encouraged the hope that testing could be made purely objective. Theoretically, if this goal were attained, the administration of a test would result in an automatically valid score with no subjective evaluation necessary. We realized dimly that this goal had not as yet been reached, but in our zeal to achieve perfect objectivity, we overlooked the necessity of also developing the subjective, interpretative skills that were still necessary. The literature is jammed with statistical materials and methodologies for obtaining numerical indices, but has relatively little on teaching the interpretative insight necessary if one is to derive all the rich clinical significance from the subject's actual test behavior. We tend to forget that a test yields us meaningful behavior for clinical evaluation as well as a cold numerical score. Fortunately, the Rorschach test and other projective techniques, such as the thematic apperception test, which do not yield easily to the objective approach, have kept alive the interest in the subjective approach.

We have already mentioned the evaluative deficiencies of test scores with their group statistical orientation when they are applied in the clinical situation to the judgment of a single individual, and the need of supplementing test score by clinical judgment. Let us take another example of the need for subjective interpretation from the use of intelligence testing as an aid to psychiatric diagnosis. If we approach this through a measure of scatter—a comparison of the various subscores within the test battery in the hope that undue discrepancies between these scores will reveal any pathological deficit that exists in the corresponding abilities being measured—we find that as yet scatter has failed to yield to an exact mathematical formulation, largely,

I feel, because the significant factors in the behavioral responses are often such that they do not appear in the mathematical scoring.

A concrete example of this can be obtained by quoting two answers to a question on the Wechsler-Bellevue, two answers that stand equal numerically in their influence upon the final score, since they are both wrong and each contributes a zero. In response to the question, "Where is Egypt?" you may get the answer, "I don't know," but I have had a schizophrenic reply, "In a manner of speaking, it may be said to be in an oasis—plenty surrounded by sand." Certainly these answers, both of equal significance in an objective scoring system, are miles apart in clinical significance. We must not forget that the primary aim of psychological testing is the sampling of behavior under controlled, standardized conditions. As a secondary convenience the behavior may be symbolized by a numerical index or test score, but only as a secondary convenience.

In the future I feel that the stress in the field of testing, which in the past has been laid on the obtaining of scores, will now shift back to the interpretation of the actual test behavior involved. This should have important implications for directing our professional efforts. Instead of spending all our energy developing tests, we should spend more time developing testers. In the past we have trained a group of people, commonly called psychometricians, who were geared to produce scores. Now we should train a group of people, clinical psychologists, whose task will be the interpretation of behavior.

It seems to me that psychometricians as such—individuals with little professional training and that mostly in the administration of tests—may disappear. Such training is not necessary for the administering of group tests. It is necessary only for the administering of the so-called individual tests given to a single subject in a face-to-face situation. With an individual test, however, it is not the administration of the test, but the interpretation of the results that counts. I fail to see any advantage that the individual test has over the group test except for the one clear fact that it gives the person administering the test a chance to observe carefully a patient's actual behavior under controlled, standard con-

ditions, and such an opportunity for observation can be taken advantage of only by a fully trained clinical psychologist.

We will see more use of group tests by relatively untrained workers who need not even be psychologists, since the whole aim of group testing is complete objectivity and the automatic rendering of an objective score. Individual tests will be given and interpreted only by trained clinical psychologists. Perhaps in the future such individual tests will be given only to those cases previously screened by group tests and as a result picked out for further study. In this respect the procedure would to a great degree resemble the processing methods used in the military services, with group tests used economically for disposing of the ordinary run of cases and the more laborious individual tests reserved only for those cases in which they are indicated. Thus in the navy a group paper-and-pencil intelligence test, the general-classification test, is given to all recruits as part of the selection and placement procedures. Only those men who score unduly low are referred to the clinical psychologist for further testing.

This must inevitably mean more attention to the procedures of psychometrics by clinical psychologists. In the past clinical psychologists have tended too often to be satisfied to turn psychometrics, the actual procedures of testing, over to relatively untrained juniors, availing themselves only of the resulting scores and completely neglecting the rich clinical opportunity of personally observing test behavior. It may be that we have failed to appreciate the clinical opportunities in the psychometric situation; it may be that we as clinical psychologists have been too quick to ape the psychiatrist and reach for the pleasures and privileges of playing doctor in the field of therapy.

Whatever the reason, there is little doubt that many clinical psychologists have been neglectful of psychometrics. Our experience in the navy has indicated that psychometrics are an important diagnostic tool, a tool worthy of all the study and development that clinical psychologists can give it. It has been one skill of ours that the psychiatrists have not been able to do without. Moreover, it has been a skill that has often made it possible for us to beat the psychiatrist

at his own game of diagnosis, since many a difficult case will yield to the probing techniques of psychometrics material that cannot be revealed in the ordinary psychiatric interview. For my part I should like to see psychologists pay more attention to this outstanding and peculiarly psychological contribution to clinical practice and less to an attempted invasion of the field of therapy.

I have argued this afternoon for more efficiency in testing procedures and for more attention to the importance of subjective clinical evaluation. Inevitably I have at times taken the extreme position and dealt more harshly with the objective approach than I would really wish to. As a scientist, I have high hopes for the objective approach in testing and certainly would encourage it at every point. Until our goal of complete objectivity is reached, however, we cannot afford to overlook all those subjective interpretative skills summed up in the word "clinical," so often used disparagingly by our statistically minded colleagues. There is no inherent incompatibility between the objective and the subjective approach. Only when they are mutually developed to complement one another will we attain sound progress in the use of evaluative procedures.

PSYCHIATRY AND THE RETURNING VETERAN

CAPTAIN FRANCIS J. BRACELAND, M.C.
United States Naval Reserve

ANY discussion of psychiatry and the returning veteran at this stage of the war must of necessity assume the coloring of a precipitate forecast of future events. Though it is true that one phase of the problem is already upon us, in as much as well over a million men have been discharged from the service, nevertheless the present situation is probably not quite a fair sample of the one that will face us at the end of the war.

The present group being discharged from the services is discharged either for medical or for administrative reasons. They are returning to an economy in which jobs are plentiful, wages are high, and the veteran question is so new that every one is intensely interested in their welfare. One can only hope that the same conditions will prevail when the millions of men return at the end of the war.

In order to keep this discussion of things to come from being no more than vague prophesies or specious forms of soothsaying, we can have recourse to three sources of data. First, we can appeal to history and learn the lessons that can be drawn from chronicles of wars and the emotional upheavals following wars; secondly, we can consider and evaluate our psychiatric experiences to date in the present war; and thirdly, we can try to interpret the trends and tendencies toward future events that may be evidencing themselves at the present time. Montaigne once said, " 'Tis one and the same nature which rolls on her course and whoever has sufficiently considered the present state of things might certainly conclude as to both the future and the past."

There have been psychiatric casualties in all wars in the past, and it is safe to conclude that there will be psychiatric

* Presented at the annual dinner meeting of the New York Society for Clinical Psychiatry, New York City, January 11, 1945.

casualties in all future wars. In an account of the battle of Marathon, Herodotus describes incidents that surely must have been instances of conversion symptoms among the warriors. In as much as the history of nations is writ large with descriptions of war and subsequent reconstruction, and economic and social upheavals heretofore have been their inevitable aftermath, we are at least forewarned of the possibilities and the pitfalls in the coming post-war period.

The classic description of post-war turmoil and unrest was written by Thucydides after the Peloponesian Wars, over 2,300 years ago, and some variations of this theme have been repeated with alarming regularity after all major wars ever since. The emphasis on the fact that distress inevitably follows major war is important, for by the words "major war" we imply not only that the conflict is widespread, but also that all classes of society are thereby in some manner involved or affected. In those wars of old in which only a few thousand knights were involved or in which an army was "rented" for the occasion, the population as a whole was not involved and consequently there was no great popular emotional upheaval when the wars terminated.

Although general unrest has been the rule in post-war periods, there have been occasions in history when, as a result of careful planning, it was kept at a minimum. A good example of this can be found in the history of Prussia. In 1809, following the Peace of Tilsit, Frederick William ceded a great part of his recently won territory, a period of so-called reform was instituted, and existing inequalities were corrected, and all was accomplished with very little difficulty It is apparently only when the burst of emotional energy that is aroused in the populace and that carries them through the war gets entirely out of hand that trouble results, for this energy, once activated, must be directed into proper channels of reconstruction.

Translating all of this into our present-day situation, we may obtain a preview of what to expect, but there are several unknowns in the problem this time. There is no doubt that all classes of society are involved in this global war, albeit some reluctantly, and there is no doubt but that we are making plans for a rapid transition to a peace-time economy when the war is over, but this time we are more dependent

upon conditions in the rest of the world than ever before. Because of the rapidity of air transportation, the advent of rocket bombs, and the speed of radio communication, no nation is any longer remote and no war can any longer be a private affair. On the surface of it, then, it appears that we will face a post-war period entirely different from any other in the history of the world. One is tempted to add "a much more difficult period," but since Cassandras have been crying that lament for centuries, we spare you that prophesy.

One thing is certain and that is that *some* of the problems that the nation and psychiatry will face after this war will be entirely new, and, therefore, from a psychiatric standpoint, any plans that we make had better be extremely flexible. After each of our own major wars, there has been a period of readjustment in which a breakdown in idealism and a lowering of the feeling of social responsibility became evident. These things are extremely important for psychiatry, and though the general post-war conditions are beyond our control or sphere of influence, they constitute the groundwork upon which our plans must be constructed.

The obvious conclusion to be drawn from the above, therefore, is that neither the future of psychiatry nor the plans for the treatment of patients with neuropsychiatric conditions can be considered as isolated problems. Just as the nation will be dependent upon world affairs and psychiatry must be influenced by the general post-war conditions, so also the psychiatric treatment of veterans must be carried on within the frame of reference of the over-all psychiatric picture. We cannot salvage one segment of a population without affecting the total economy and attitudes of the remainder. No group can be separated from the larger body of which it is a part for long without causing some friction. We cannot treat the veteran while neglecting his family and expect the treatment to work. I should like to elaborate upon this a little later.

The second source of data that will aid us in our thinking about psychiatry and the returning veteran is a consideration of our psychiatric experiences to date in the present war. There is no need to dwell upon the difficulties encountered early, particularly with psychiatric screening at induction stations, for most physicians were in a position to form their

own opinions about that problem. The navy tried to bridge the gap by reëxamining the men at naval training centers. This reëxamination had several advantages. It allowed a careful and close scrutiny of the recruit's status and performance while evaluating his present ability to adapt. I am sure that this screening was of great value, for it eliminated many more men who were potential psychiatric casualties.

The neuropsychiatric problems encountered in the navy in this war are in many ways unique. The size of the forces involved, the setting and the circumstances in which most of the naval warfare has been conducted, the vast distances involved, the island warfare in tropical climates, the mobility of the task forces, all compel us to think and plan in terms of discontinuity.

During these three years of war, some of us have changed our concepts of psychiatry in the naval service. We are more than ever convinced that there are two kinds of psychiatry and that there is a gulf between them. The first is academic psychiatry, the kind we read and write about in books, the kind we like to practice under ideal conditions in civilian life. The second is military psychiatry, the kind that is influenced by military necessity, by medico-legal, social, and ethical requirements, the kind in which our beliefs are based on academic concepts and our activities are dictated by pragmatic necessity. Our judgments are made upon an evaluation of the individual's effective performance. One thing we must continually keep in mind—the purpose of an army and a navy is to fight; all other functions must be secondary.

In our civilian psychiatric practice, we accepted symptoms presented as fixed things, and proceeded to evaluate them. In naval psychiatry, we add up the symptoms, consider the situation in which they occurred, relate them to the effectiveness of the individual, and make our final decision with the welfare of the group and of the individual in mind.

The question arises whether or not our functional approach is not a perversion of science. We do not believe it is. We feel that psychiatry can function on an over-all basis only if we adapt it to the needs, demands, attitudes, and customs of the people. If a maiden should arrive in the Park Avenue office of a psychiatrist with a ring through her nose,

yards of brass around her neck, and wearing a loin cloth, she might be a candidate for a spinal tap. In Fiji she might be made a princess. Likewise, if ninety-nine out of a hundred men who were repeatedly bombed exhibit anxiety symptoms, that anxiety is normal under the circumstances. We must avoid stereotypy. We can evaluate symptoms only within their own frame of reference. It is important for the psychiatrists who are to treat returning veterans to understand this, for otherwise there will be confusion about some of the patients who apply to them for help.

We are particularly careful now with our diagnostic labels. We are convinced, for instance, that prolonged exertion, fatigue, exhaustion, and a host of other similar factors can induce a symptom picture that is all but indistinguishable from the classic psychiatric syndromes. There is this difference—rest and respite from the situation of stress can restore these men to a state normal for them in a surprisingly short period of time. We prefer to wait for this outcome before making a final diagnosis. To insist upon the usual form of psychiatric diagnosis under these circumstances is to win an academic Pyrrhic victory, with consequent hardship for the man and loss to the war effort.

Let me quote from the recent report of a psychiatrist who was assigned to a remote island in the Pacific for over a year: "I recognize the problems of all of my psychoneurotic patients, but through experience have learned that I cannot handle them by ordinary civilian methods. Psychoneuroses had to be established as non-disabling illnesses. Whether it is heresy or not, neurotic patients are suspected of exaggerating their complaints and malingerers endowed with the benignity of unstable nervous systems. I listen to the problems of the malingerers with the patience and understanding due a man suffering a disorder not of his own choosing and I do not hesitate to use therapeutic disciplinary measures in nervous men who have not learned to discipline themselves. Adjustment and understanding must be made here and now." This man is one of the most capable and most efficient psychiatrists in the service.

After the last war, it was frequently stated that many emotional problems precipitated by combat experience cleared up on Armistice Day. It was implied that once a man was

removed from further contact with the war, he recovered. This idea also has not been confirmed in our experiences in this war. Raines and his co-workers report a large series of cases in which they note, "In spite of the situational precipitation of these disorders, relief from active duty alone does not result in recovery. Not one of our combat-fatigue cases whose illness has outlasted the naval-hospital stay has recovered upon receiving a discharge from the naval service." They state that good evidence of the ultimate recovery of these cases has been received, but the reports convinced them that time and assiduous care were required to accomplish the recovery.

Another question that has aroused much discussion in and out of psychiatric circles in this war is whether or not a normal individual has a so-called breaking point under combat conditions. We believe that the normal individual can break down under certain conditions, providing the stage is properly set. We believe that some of the diversity of opinion on this subject is due to a difference of interpretation of the words "breaking point." By this term we mean a point after which the individual is no longer effectual, because of emotional symptoms, and we consider this point to be fluid, not fixed, and to vary under certain configurations of circumstance and time.

At this point we might mention briefly in passing the problem of psychoses in the navy. Thus far they have been extremely and gratifyingly low, much lower than any comparable civilian rates. The recovery rates following psychosis have been high and rapid, but they really should not be evaluated until more time has elapsed. In a follow-up study of 100 recovered psychotic patients one year after discharge from the hospital, approximately 80 per cent of them were found to have made a very satisfactory work adjustment in their home communities.

There is another aspect of an important problem that requires some elaboration. The psychological stress of war is different from the psychological stress of warfare. As mentioned before, the global nature of the present conflict has affected both civilian and military population, but in varying degrees, and as a consequence the normal state of tension has been heightened. Morale, which reflects this state

positively or negatively, is not a self-contained process. It has a direct bearing upon the attitude of the military personnel, who have as a result two burdens to bear—their own pressing and immediate personal danger and their interest in and concern over the state of affairs at home.

You are familiar with the psychological effects of this double burden. An example is the service man at the front who bears up well under combat only to have his adjustment undermined by the seepage of poor morale from home. The news that was reaching the men for a while did little to bolster their morale. When they heard of discord on the home front and failure to recognize the gravity of the situations that confronted them, they were distressed. That they did so well under these circumstances is testimony to their high caliber, and it is hoped that the recent evidences of renewed efforts and a generalized tightening up at home will encourage them.

These, then, are some aspects of the psychiatric situation as we have experienced it thus far in the present war. One thing these experiences have done for the military psychiatrist—they have broadened him and made him ready to undertake numerous difficult tasks under unfavorable conditions. At the beginning of the war, we were not very well equipped to handle the situations that were soon to confront us. It was believed by every one in psychiatry that psychological warfare, propaganda, leadership selection, morale building, and various other things were, in their essence, within the psychiatric province, yet the preparation of most psychiatrists for these undertakings was a somewhat constricted experience with the mentally and emotionally ill. The group who felt most keenly the lack of a socially integrated perspective were those service psychiatrists who were confronted by the problem of dealing with hundreds of patients. This group found their training inadequate, their concepts antiquated, their terminology unhandy, their treatment limited in scope and value, and their prognostic ability doubtful.

Quite naturally, psychiatrists, as an authoritative group, were consulted in an effort to obtain some counsel and guidance on huge war-time problems, many of which had post-war implications—such things as the significance of the atti-

tudes of conquered peoples, the best methods to be employed in morale building, the problem of mass-scale prophylactic psychiatry, and so on. In other words, some one had been bragging about our abilities as lion-tamers, and we soon found that we had a lion by the tail. How well we are doing will be a matter for the psychiatric historians to decide, but I regretfully have to tell you that some of the doctrines upon which we were nurtured have been of little help to us.

Not the least of our inadequacies, we soon learned, was the lack of an understandable language. Very few of the psychiatrists entering the service could agree upon the definitions of various terms or the implications of the diverse psychiatric diagnoses. These defects did not help us in our relationships with our medical brethren, and the practitioner's lack of common knowledge of simple psychiatric doctrine was further testimony to psychiatry's insularism. Our medical confrères were in doubt about our ability and were of the opinion that if we had anything to offer them, it had to be decoded before it could be utilized. Fortunately, some inroads have been made on this problem as a result of the excellent work of the service psychiatrists, who in the face of many difficulties have done an excellent job. With very few exceptions, they have proven to be adaptable, hard-working, capable physicians who have made their way and earned the respect not only of their colleagues, but also of hard-bitten and battle-experienced line officers. These facts are of great importance for the future. Medical officers have become accustomed to service from psychiatrists, they have found that they can get helpful opinions couched in language that they understand, and this will be expected of psychiatrists in post-war practice.

If, after all of this, one is justified in drawing some conclusions as to the relationship of psychiatry to the returning veterans, it is time to do so. If we are permitted to divide psychiatry into various eras, it would appear as if we are on the threshold of a new era, drawn thither by forces outside of ourselves as well as in recognition of our own deficiencies. What this era will be called, no one yet knows, but one thing is certain—it will have to be of wider sociologic importance. We will not be alone in these trends, but simply accompanying the rest of medicine, which is apparently moving or being

drawn in the same direction. I am not speaking now of the socialization of either medicine or psychiatry. I have no pet theories to offer. It is as Brigadier General Rankin remarked: "Tremendously forceful socio-economic trends which are involved and deeply concerned with the nation's medical problems are directed toward some form of national health service as an integral function of the state—to recognize it must not be considered in the nature of apostasy."

It is difficult on this plane to limit our discussion to the immediate; one is tempted to try to answer the question, "*Quo vadis?*" for psychiatry. No one knows the proper answer to this question, but it is a step in the right direction to realize that the question requires an answer.

We have previously noted that there has always been a veterans' problem and in our more depressed periods we think that there probably always will be one, yet their problem is not unique. Veterans do serve as an excellent focal point, however, and around them some constructive thinking for psychiatry can be formulated. Perhaps, if psychiatry concentrates upon the proper handling of veterans, we will learn many things that can be applied in civilian practice.

Certainly the same problems that the veterans present are equally pressing in any number of groups on the home front. Certainly the dislocated wives and children and families will be entitled to consideration, particularly as there is now no organized civilian body interested in tending to their needs. We have stated before that this is a total as well as a global war; we cannot, therefore, simply isolate one group for postwar care and neglect the others. The efforts of psychiatric rehabilitation programs, as well as of all other rehabilitation programs, will have to be bent toward adjusting the veterans to their proper places in society instead of treating them as a group apart. It is necessary to avoid any further cleavage of veteran and civilian groups. Just as one cannot isolate the heart or kidney from the body and treat it, so also we cannot isolate the veteran and treat him apart from the body politic.

The veterans' economic, social, and domestic problems are but concentrated and exaggerated examples of the problems of other persons. That their fears and anxieties were uncovered during the course of active combat service makes

them more pressing, but not necessarily more poignant. These statements are by no means intended to minimize the needs of the veteran, for, like yourselves, I believe that he is entitled to the very best of care obtainable. I am simply attempting to vocalize the requirements of those whom the exigencies of war have forced into the background.

It is to be hoped that in planning for the future treatment of veterans and civilians, we do not conceive of it entirely in terms of the past. Except for the better clinics and the larger centers, the out-patient-department treatment of psychoneurotic patients was in many cases simply a salve to the collective consciences of the hospital management. Certainly we need shorter, more active forms of therapy and a sharper delineation of our functions. Investigations along the lines of group-therapeutic methods should be encouraged, for it is hardly possible that we shall ever have enough psychiatrists to go around.

Clinics need to be set up, not only in urban centers, but also in out-of-the-way places, even if they can be staffed only by visiting psychiatrists—psychiatric circuit riders, if you will. It would seem most logical to make plans to train and equip the general practitioner and the specialist in other fields, so that they have at least some knowledge of psychiatric problems. This could be done by arranging courses through the county medical societies and bringing the problem before the attention of all physicians. They are more ready to learn than ever before, but we must have satisfactory plans for teaching them.

Our medical educators need some reorientation, and they will listen to us, providing we have definite, concrete plans as to what constitutes a satisfactory psychiatric curriculum. Heretofore, we have made surveys of facilities in medical education and then have written about it in books for psychiatrists and for psychiatric societies, and they were never read by the people who needed them most. It is probable that we will have to alter materially our methods of approach to our medical colleagues. We, too, must submit ourselves more to scientific discipline and make our doctrine concrete enough to be able to present it to physicians in ordinary medical parlance.

These statements are, of course, not intended to minimize

the fact that we must train many more psychiatrists, but the problem is bigger than just that. There is need for many more trained psychiatric social workers, psychologists, occupational therapists, and so on, and there is room enough and work enough for all in the fields adjacent and adjunct to psychiatry. It is possible for all of these groups to work harmoniously in a licit symbiosis which will redound to the benefit of all concerned. Again, however, this all needs careful planning lest perhaps in our haste we construct a jerry-built treatment structure, neglecting some functions and inadvertently encouraging the rise of some peculiar form of emotional chiropractic therapist.

At the risk of being thought a heretic, I should like to draw several analogies between psychiatry and military action at this point, for they might be considered timely. We have read on occasions that an army has extended its lines too far and is vulnerable to flank attack because it is too far from its base of supplies and is spread out too thinly. Should we not be more careful in psychiatry, so that we are not attacked while our lines are overextended? Are there not times when we have spread our doctrine somewhat thin and cut ourselves off from our bases, which are made up of solid facts and which are scientifically demonstrable? Are there not times when we would be found vulnerable to a blitz from the air in the form of clear, cold logic? The point that I am trying to make is that we should recognize that psychiatry has its limitations, and that its tenets are not applicable to all fields of knowledge.

Much of our former difficulty is probably due to the fact that workers in other fields borrowed freely, but not always wisely, of our concepts and not infrequently misapplied them. Thus some biographers, educators, sociologists, and others have frequently usurped our jargon and by its indiscriminate use have sought to attain stature by becoming pseudo-scientific. Sometimes when a man becomes famous and receives acclaim for some accomplishment, people are prone to regard him as an oracle and to seek his opinion on all subjects. Thus we are treated to the spectacle of world-renowned physical scientists or internationally-known manufacturers making pronouncements on things philosophical, religious, or psychological. Not infrequently, they are widely

quoted in a manner that can only appear ludicrous, and the individual loses stature because he has strayed from his field. The same danger awaits us in psychiatry when we stray too far afield and are euchered into giving opinions or interpretations of things foreign to our discipline. It is obvious that there still remains enough work to be done in our own field to occupy all of our attention, and this brings us to our next analogy.

Before preparing for a large-scale offensive, an army is withdrawn, supplies are gathered, men are rested and equipped, and armament and ammunition are assembled. We can conceive of psychiatry's preparing for a large-scale offensive at the end of the war if we are to fulfill our mission and aid those who will have emotional difficulties. Would it not be wise for us to examine our armament and our ammunition before the large replacements of young psychiatrists arrive to aid us in the battle? Should we not even reëxamine some of our basic postulates, to make sure that everything is in order?

There are many places in which we might be attacked. Let me mention just one that occurs to me. Our medical psychology developed its concepts on the basis of a study of abnormal mental facts and abnormal individuals. At times it proceeded to generalize the conceptions it had noted and without hesitation or misgivings applied them to normal minds. The reason for this is probably to be found in the habit of thought characteristic of the nineteenth century—namely, the habit of looking for an explanation of the higher phenomena among the lower or even elementary ones. It was the general belief that disease brings forth by disintegration these elementary phenomena. Are we positive that our reasoning is sound?

There is no convincing reason for believing that disintegration will bring forth the constituent elements of an object. By blowing up a bridge, one does not recover nicely separated bricks, concrete, steel, and rivets. What is recovered is a mass of fragments that are definitely not integral parts of the bridge that was destroyed. Is it permissible to submit the postulate that the same thing can be said of most mental crack-ups? If we were to state that intelligence is a minimum of idiocy, we certainly would be criticized and the

idea characterized as nonsensical. Are we likewise open to criticism when we regard the normal personality as if it were the minimum of neurosis?

This may all seem like gross exaggeration; as a matter of fact, some of it is, but my point is that some of our concepts require reëxamination and the questioning of them must not be regarded as treason. We have already observed in this war that unless the reaction described is examined in the light of the circumstances under which it occurred, we come out with the wrong answers. We find but little evidence of the existence of universals in military psychiatry.

I had not intended to deviate so far; it seems as if I have lost sight of veterans' problems. I warned you, however, that the consideration of the future of the veterans would serve simply as a focal point for a somewhat general discussion of our future projects. I regret exceedingly that I am constitutionally and intellectually inadequate when it comes to giving any of the answers to these problems. As one of the hewers of wood and drawers of water in this present strife, I am like Martha in the Scriptures—"busy and troubled about many things." I am in a position to see the need for the things I have mentioned, however, and I present them with due humility for your consideration.

Before closing I should like to pay tribute to a great group of men who are doing excellent work—the psychiatrists of the army, the navy, the Public Service Health, and the Merchant Marine, your colleagues and mine. They are spread throughout the world to-night, and, like every G.I. Joe, they tick off each day with the hope and the prayer that it brings them that much nearer home. They are among the hardest working of the hard-worked medical officers and they have earned the respect of their patients and their co-workers alike.

The relationships among the psychiatrists of the various services are excellent, as befits men whose duty it is to teach the acquisition of emotional maturity. It is always distressing to encounter feuds among physicians and inexcusable to encounter it in psychiatrists. Thus far there has been no evidence among the services of the justifiable lament made by Dr. Alan Gregg when he said: "Men who are personally delightful, when armed with the saber of their particular belief and clothed with the toga of their knowledge, become

impossible with their medical brethren." The cordiality exhibited among the psychiatric branches of the military services has resulted in mutual benefit to all concerned and, most important of all, has redounded to the benefit of the men under our care.

Finally I say to you, everything is unknown about the future save this alone—when the ideals for which we are fighting prevail, the future will offer all men some dignity and a chance for self-improvement. I believe that psychiatry has an important part to play in that future. The return of the veterans and their need for psychiatric assistance will present us with an unparalleled opportunity for service to them and to their fellow citizens. The occasion will be piled high with difficulties and we will have to rise to the occasion. We cannot afford to fail—we have promised too much. There can be no thought of petulance, division, or factional strife among psychiatrists above all. No matter what their persuasion, it is now and will be truly a time for greatness.

MENTALLY RETARDED BOYS IN WAR TIME

REBECCA M. McKEON
Worcester, Massachusetts

CAN mentally retarded boys contribute material help in time of war emergency? Are they responsible for a large part of our juvenile delinquency? Because their academic progress is slow and limited, and because they are unable to learn from experience or to foresee the consequences of their own acts, they present many problems to the community that must be responsible for their training. Much scientific attention has been given to their education, large sums are expended in their behalf, and laws have been passed for their welfare. Are they, then, likely to become self-respecting wage-earners and law-abiding citizens? Can they really offer anything to society?

Carefully planned follow-up studies of those who have attended special classes adapted to their needs will help to answer these questions. Such a survey has been made recently in an industrial city of New England not far from Boston and has brought forth interesting facts very creditable to the efforts of the boys in question.

The study included a period of ten years from 1932 through 1942, during which time 1,055 boys had left the special-class center of the city. From their names on file in the clerk's office of the school, every fifth name was selected, and the group of 210 boys of the study was thus determined.

These boys, whose ages, at the time of the investigation, ranged from sixteen to twenty-seven years and whose I.Q.'s from 52 to 83, had received limited academic training; few of them had achieved success beyond grade-four level. About 80 per cent of the group had left school as soon as they had reached the age of sixteen, the compulsory-school age required by state law. They had attended special classes on an average of four years and nine months, during which time the emphasis had been on handwork skills, good health

habits, and the development of desirable personality traits. More than two-thirds of the boys came from homes rated below average.

The investigator had been a teacher in this special-class center during the full period of the study and knew the boys personally. She visited their homes and interviewed the boys themselves, or some near relative in the home if the boy himself were away in service.

In many cases the boy and his people showed unmistakable pride in the fact that now he could give a good account of himself and could measure up with others in that he, with them, was serving his country. Pictures of those who were serving in far-away places were prominent in some of the homes; bonds were being bought in their names, and in some cases the concerns for which they had worked had set an example in this. On two occasions the writer made a visit just after the arrival of an official telegram, and was requested to read of the boy for whom she was inquiring the news that he was reported as missing in action.

Love and pride were not expressed in every home, however. Sometimes it was relief because, after long idleness, the boy had at last found a job of some permanence; sometimes it was indifference, sometimes complete ignorance. In one case, it seemed something close to hatred that prompted these words from a lazy, unkempt mother: "What do you want with that good-for-nothing? I kicked him out eight years ago and will kick him out again if he comes back when he gets out of jail this time." More than one resource seems to have failed some of these boys.

At the time of the survey, 113 of the 210 boys were in active service; one of these had been rejected by the United States Army and again by the United States Navy, but had been serving for five months with the English Navy when he visited the school. Further data of the study show that in the fall of 1943, when the investigation began, 76 of the young men were at work in the city,[1] eight were in institutions, seven were still at school, one was an invalid at home,

[1] One of this group was a newsboy of very low mentality who was mostly dependent on relatives. He is, therefore, counted as a worker, but is not included in the group of wage-earners.

one had just received a medical discharge after seventeen months' service with the U. S. Marines, and four were dead.

Three members of the group had died before the United States entered World War II. The military status of the remaining 207 young men showed that in addition to the 113 in active service, one had already been killed in action, three had received medical discharges after participating in major battles, and 16 were awaiting draft. The navy had rejected three as incapable of completing their basic training, and the Selective Service boards had rejected 36. Deferred and working at defense jobs were 17 young men, while 18 others were still too young to be eligible for service. Thus, 117, or slightly more than 56 per cent, of the 207 boys who were alive when the study began, served in the armed forces and 39 of the group, or about 19 per cent, were rejected. Table I gives these data.

TABLE I.—MILITARY STATUS OF 207 INDIVIDUALS IN THE STUDY

Status	*Number*	*Per cent*
In active service	113	54.59
Deferred and working at defense jobs	17	8.21
Awaiting draft	16	7.73
Rejected by Selective Service boards	36	17.39
Rejected by the navy	3	1.45
Honorably discharged	3	1.45
Died in action	1	.48
Ineligible	18	8.70
Total	207	100.00

Twenty of the 39 young men who were rejected were classified as mentally or educationally inadequate, while 11 were rejected as physically inadequate, and eight for administrative reasons (some of these having court records against them). Table II shows these facts. Of the 11 who were physically handicapped, four had organic heart trouble, two were deaf, two were lame, one had lost an eye in early childhood, one had spinal curvature, and one had ulcers of the stomach.

Among those who had more academic training than that offered at the special-class center were eight boys who had gone on to the Boys' Trade School. They had been admitted for an "all shop special" program, and under close super-

TABLE II.—STATUS OF 39 INDIVIDUALS REJECTED FOR SERVICES

Cause of rejection	*Number rejected* By board	By navy	Total	*Per cent*
Mentally or educationally inadequate	17	3	20	9.66
Physically inadequate	11	0	11	5.31
Administrative reasons	8	0	8	3.87
Total	36	3	39	18.84

vision and careful guidance had succeeded in meeting the requirements for the shop program; two were successful cabinet-makers, two were carpenters, one had become an auto mechanic, one a brick mason, one a pattern maker, and one had proven particularly efficient at painting and decorating and had been employed steadily by one of the best interior-decorating firms of the city, which rated him an excellent workman and paid him good wages.

With very few exceptions, the boys in this study had found work at unskilled or semi-skilled labor and had done so with little help. Table III gives a summary of their occupations, not including their work in the armed forces.

TABLE III.—OCCUPATIONS OF INDIVIDUALS IN THE STUDY

Occupation	*Number*	*Occupation*	*Number*
Clerks	14	Laborers	18
Delivery service	108	Machine operators	64
Drivers	68	Miscellaneous	30
Farm work	12	Odd jobs	22
Garage work	18	Own business	5
Government projects	43	Painters	6
Helpers	143	Repair service	25
Hospital workers	4	Restaurant workers	12
Hotel workers	15	Tradesmen	11
		Total	618

It is interesting to note that of the entire group, there were but two boys who had been employable and had never worked. One of these had been out of school and idle for six years when sent to a penal institution for life on a charge of murder; the other had been out of school four years when sentenced for the second time for larceny.

This city offers a wide variety of work to young men who attend special classes. By far the greater number of these jobs, however, are rarely chosen by the normal boys for more than temporary work. It is perhaps this lack of competi-

tion with the more capable that makes it possible for the mentally retarded youth to become permanently employed at these routine tasks. The personnel manager of one of the shops that employs many of these boys remarked to the investigator that after the boys from special class were trained, they made more satisfactory adjustments with less turnover of job than did many of the more intelligent workers, who felt that the type of work was beneath them.

It is to be noted that this investigation took place at a time when the impetus of World War II was being felt in all industries. Boys who were less than eighteen years of age were found to be employed as machine operators and receiving much higher wages than if they were helpers on trucks, as would be more typical for mentally retarded boys of that age under normal conditions.

In November, 1943, 75 of the total group were employed and earning wages; 17 were in defense plants, and 58 in other jobs of various kinds. A summary of the occupations of these 58 is shown in Table IV.

TABLE IV.—OCCUPATIONS OF 58 YOUNG MEN EMPLOYED OTHERWISE THAN IN DEFENSE WORK IN NOVEMBER, 1943

Occupation	*Number*
Baker	1
Clerk	1
Drivers	10
Elevator operator	1
Helpers	10
Laborers	5
Machine operators	9
Restaurant workers	4
Shoe-shop workers	17
Total	58

Many of these boys were very recently out of school. The age range of the group was from seventeen years to twenty-six years, eleven months, with a median age of eighteen years, four months. Their I.Q.'s ranged from 52 to 83, with a median I.Q. of 67. The youngest member of these workers (I.Q. 77), was just seventen years old; he was operating a doughnut-making machine in a large baking company and earning $22.50 weekly. The oldest was twenty-six years, eleven months of age (I.Q. 61); he was married and the

father of two children; he owned three taxicabs and was earning an average of $100 a week at the time he was interviewed.

The boy whose I.Q. was 52 was twenty-four years old. He had been employed as elevator operator in a factory for five years. He was of pleasing personality, well liked by his employers, and was receiving $30 a week when he was visited.

The boy with the I.Q. of 83 was from a very inferior home. When interviewed, he was just eighteen years old and had worked steadily from the time he had left school at sixteen years of age. He was employed in a shoe factory, where he had received several promotions and was earning $28.75 weekly when visited.

One enterprising boy (I.Q. 61) worked as counter man in a lunch cart at $20 a week. He saved his money and bought a car which was badly in need of repair. With the help of some friends, he put the car into good condition and sold it at a profit. He next bought a small truck in bad condition and repaired, refinished, and sold it to good advantage. He repeated this until he had a sizable bank account. When he was interviewed, he told the investigator that he was planning to buy a share in the lunch cart in which he was employed. Since that time he has carried out this purpose and has become part owner of the business at the age of nineteen years.

The weekly wages of this group were carefully checked. The range was from $15 to $100, with a median wage of $28.50, as shown in Table V.

TABLE V.—WEEKLY WAGES OF 58 INDIVIDUALS EMPLOYED OTHERWISE THAN IN DEFENSE WORK IN NOVEMBER, 1943

Weekly wage	*Number*
Under $20	7
$20–$24	9
$25–$29	21
$30–$34	12
$35–$39	2
$40–$44	5
$45–$49	1
Over $50	1
Total	58
Median wage	$28.50

At the time of the investigation, 17 of the individuals in the study had been deferred by the Selective Service boards and were employed in defense work. Of this group, 11 were married. The age range was from nineteen years, ten months, to twenty-seven years, four months, with a median age of twenty-four years, three months. Their I.Q.'s ranged from 56 to 73, with a median I.Q. of 66. They were a well-adjusted group, self-respecting and self-supporting and contributing to the welfare of the community. Their occupations are summarized in Table VI.

TABLE VI.—OCCUPATIONS OF 17 INDIVIDUALS EMPLOYED IN DEFENSE WORK IN NOVEMBER, 1943

Occupation	*Number*
Electric-motor operators	2
Foundry workers	2
Lathe hands	4
Machine operators	8
"Set-up man"—machine	1
Total	17

Among this number was a young man, twenty-six years of age, whose I.Q. was 73. He had been a delinquent, with five charges of larceny against him. When he first left school, he had been idle for a long period and had been sentenced twice to terms in the reformatory. His only job had been that of messenger boy. When he tried to enlist, he was rejected because of his police-court record. He had been advised by the Manpower Commission to get work in a defense plant and had finally been able to do so. He had begun as a machinist's helper; at the time he was visited, he was extremely enthusiastic about his job as operator of a wire-cutting machine and declared that it was a real job, that he loved it, but that he really wanted to clear up his record and join the army. He was living with his recently widowed mother in a neat four-roomed flat which he had completely refurnished for her. Earning $55 each week, he was buying bonds at the rate of $10 weekly.

Another young man in this group was unusually successful. He was twenty-six years old (I.Q. 72), was married, and had two children when interviewed. He had been employed steadily since leaving school in spite of many diffi-

culties in obtaining employment. He had been a messenger boy, an orderly in a hospital, a houseman in a fraternity house, a laborer for a construction company; he had operated a bottling machine in a beverage company. He had found each job for himself; just as soon as the economic depression forced him out of one job, he sought another. He repaired radios and other electric equipment, made and sold wreaths, did many odd jobs, and in most energetic fashion kept himself employed throughout the depression. For six years he has worked for a manufacturing concern that rated him as an essential worker, "very reliable and thoroughly competent." He has become their "set-up" man for a certain type of machine, with a weekly wage of $72.

The 17 defense workers in the study were receiving weekly wages ranging from $35 to $72, with a median weekly wage of $48, as shown in Table VII.

TABLE VII.—WEEKLY WAGES OF 17 INDIVIDUALS EMPLOYED IN DEFENSE WORK IN NOVEMBER, 1943

Weekly wage	*Number*
$35–$39	4
$40–$44	4
$45–$49	2
$50–$54	3
$55–$59	2
$60–$64	0
$65–$69	1
$70–$74	1
Total	17
Median weekly wage	$48.00

The employment history of the 210 individuals included in the study reveals that 16 had never been employed, that three had left school to enter military service, and that six others had enlisted immediately upon leaving the Civilian Conservation Corps. One-fifth of the total group had been employed 100 per cent of the time. All of the remaining members of the group had had periods of idleness; facts regarding these periods of unemployment are based on statements of the boys themselves or their near relatives and are as accurate as their memory and careful consideration permitted. More than 77 per cent of the group had been employed at least 50 per cent of the possible time.

As to delinquencies, the study revealed that less than 25 per cent of the group had ever appeared in court to answer to charges against them. While 22 of these young men had only one charge each against them, 29 were repeated offenders. The most common charge was larceny. Slightly more than 10 per cent of the entire group had spent time in an institution for reform.

It must be admitted that no general conclusions can be drawn from one study of this size, but it seems fair to point out that these mentally retarded boys, including a wide range of I.Q.'s, were willing and energetic workers when economic conditions permitted their employment; most of them found work at unskilled or semi-skilled jobs; more than one-half of them served in the armed forces; three-fourths of them showed no delinquent tendencies. In brief, it may be said that they were found to be a self-respecting group who responded in creditable fashion to the war emergency.

MUSIC IN MILITARY MEDICINE

FRANCES PAPERTE

Music Research Foundation; Director, Department of Applied Music, Walter Reed General Hospital, Washington, D. C.

FOREWORD

When gay or grave, when worried or elated, we may hear in music an expression of our feeling and find some mitigation of its excess. Music has been called the universal solvent of emotion. Since we are eager to press into service every force that may help those whose emotions are out of balance, many studies have been made on ways to harness the helpfulness of music and apply it to the treatment of the mentally ill. Already we have sufficient knowledge—if we will but follow the experience of those who have done such work year in and year out—with which to make music more useful in our hospitals than it has ever yet been. Few of us have analyzed the principles underlying those procedures to such a point that we can inculcate them in classroom or lecture hall. Voices that rise on the topic "music therapy" may sound the lilt and clamor of victory, but too often their words do not convince us. There is need of further study and presentation of experience; analysis and formulation will come later.

Frances Paperte and her associates have been working for months in a great army hospital. Their experience has been interesting and they are commendably ambitious to make it of value to others. Accordingly they offer this report.

SAMUEL W. HAMILTON, M.D.

PHYSICIANS and musicians alike have desired more accurate knowledge about the value of music as an accessory therapeutic tool. Extravagant claims have been made regarding its efficacy, but few claims have been substantiated by carefully measured and controlled conditions. The present world conflict has added impetus to this desire to know, since no tool that has any value should be left unused

in the restoration or improvement of the thousands of war casualties.

Music as medicine is by no means a recent discovery. Many examples of the use of music as therapy are recorded in history. Probably the first written observation on the influence of music upon the human body is that in Egyptian medical papyri, discovered at Kahum by Petrie in 1889, dating back to 2500 B.C.

Music has been purveyed to hospital patients for many years. In some instances patients are free to go where music is applied, and in others music is brought to a ward either by radio or phonograph or by a musician in person. The groups involved have been heterogeneous, however, and recorded data concerning the effects of the music have been minimal.

On authority from the Surgeon General's Office, a study in the controlled application of music according to a predetermined plan was undertaken at Walter Reed General Hospital. The present paper is a report on this six-month study. It is hoped that it will answer some of the hundreds of inquiries concerning the project that have come from colleges, hospitals, organizations, and individuals in nearly every state in the Union as well as in Great Britain and Canada.

The primary objective of the study was to determine whether music presented according to a specific plan could temporarily or permanently bring about such changes in the individual as to hasten his recovery. Possibly the simpler approach would have been to focus research activities on cases commonly recognized as psychosomatic, such as the endocrine dysfunctions or gastrointestinal or hypertensive disturbances, in which the measurement of results can be more objective. However, since the pathway of action of music is by way of the emotions, psychiatry—the branch of medicine concerned primarily with emotional states and deviations—was the department selected in which to initiate the study.

In this pioneer work the following technique was employed: The medical officers selected patients for the study who presented certain symptoms. These patients were classified according to their predominant symptoms and their level

of musical intelligence. The medical officers indicated on the prescription form not only the classification, but the mood and behavior change that was desired.

The psychiatric diagnoses obtaining in these patients were almost wholly in the psychoneurotic group rather than the psychotic. This choice was deliberate because the psychoneurotics were in the majority, and also because, for the first time in our history, large numbers of people officially classified as psychoneurotic were gathered together in one place, and no better opportunity would be likely to present itself for studying this group. As the medical officer in charge stated, "The psychotic we have with us always."

Control cases were selected by the medical officers and were given identical treatment except that they received no musical applications. After selection and classification, each patient was then interviewed by the musical director to determine his "musical level," and was classified on the basis of this evaluation into one of four groups: (1) little or no familiarity with any music; (2) moderate familiarity with the simpler forms and expressions of musical composition; (3) educated musical taste or preference; (4) some degree of experience in participation.

This interview was conducted quite informally, but with definite direction and plan, so that when it was terminated, all manner of pertinent data on the individual were available for use by the musician. These data included background information, the patient's home state and home town, his occupation, the nativity of his parents, the schools he had attended, the places he had been or wanted to go, his branch of service, whether he had been overseas, and where. The things that lay close to his heart might often be brought to him through music.

Patients who fell into similar classifications—*e.g.*, "Restlessness—educated musical taste—soothing therapy," or "Depression—moderate familiarity with music—stimulating therapy"—were then assigned to small groups of from three to six members. A specific hour for the application of the music was arranged for each group and it met regularly at the same hour, five days a week. The duration of the treatment varied greatly, but was basically determined by the

length of hospital residence, an average of twelve days before transfer or discharge.

The physical environment of the sessions was carefully ordered so as to predispose to a feeling of comfort, relaxation, and informality. The predominant color was subdued, but not somber. Chairs were upholstered and there were facilities for reclining. The musical instruments were in the room and plainly visible, but were not given dominant position.

The piano was the instrument chiefly used, although violin, cello, harp, and solovox attachments were also employed. An expanded study might well include the comparative value of the various instruments.

The musical-treatment sessions were divided into three parts:

1. The introductory or mood-determination and development period. Compositions selected with the aim of meeting the patients at the mood level that they brought to the sessions were played in order to establish a basic rapport between the patients and the music. Then, gradually and without any abrupt transition, music designed to develop the feeling tone prescribed by the medical officer was presented, simply and without obtrusion of the musician into the picture. The duration of this part of the session varied according to the patients' span of attention as carefully observed by the musician or session manager.

2. A brief interim period for establishing verbal rapport between patients and musician should the patients feel so inclined.

3. The period of patient participation. No direct invitation was issued, but the informality of the environment was conducive to this goal. Participation might be in the form of comments, queries, requests, or through humming, beating time, singing, whistling, or following the score. Whenever any patient showed especial desire or aptitude to express himself through music, he was encouraged to do so through arrangement for private instruction as well as through participation in group sessions. The results obtained in the limited number of cases that received such special instruction

in music served to verify our expectations that this was an important aspect of therapy.

In the beginning, our ideal was more nearly achieved than at any other time because, although we could not add a full-time psychiatrist to our staff, an interested medical officer offered to devote all his spare time to our project, seeing and interviewing our patients daily and charting reactions. We also had an extremely gifted staff pianist, experienced in the use of music and deeply interested in the potentialities of the situation. She coöperated closely with the director, playing selected and planned programs daily, and teaching such individuals as were referred to her as well as assisting in the keeping of records.

This plan originally called for no continuity of musical personnel, but rather that musicians of merit and outstanding talent be recruited and give of their time and skill to the project without remuneration. This was actually done, but experience led to the opinion that this plan was neither desirable nor feasible, since it is not practicable to instruct fresh talent daily in the special art required in such a project. Likewise, in any research endeavor, the variable factors should be reduced to a minimum, and, therefore, the constancy of the musician or musicians is of great importance.

The personality qualifications of the musicians were of paramount importance. Especial difficulty was encountered in getting musicians to understand that the sessions were not intended to present opportunities for their own emotional expression or demonstration of the brilliance of their techniques, and that the spotlight was on the patients rather than on themselves. The extent and degree of their adaptability to the project was the most important consideration. Whereas they needed the skill of true artists, this alone was insufficient recommendation. The personality of the performer seemed to exert a definite influence upon the response of the patient.

The classification of the music presented was a never-ending task. A committee of musicians prominent in national musical life devoted a great amount of time to placing all the musical selections used into a practical classification.

The criteria for this first general classification were as follows:

I. All music for use in hospitals, as per the Institute of Musico-Therapy's plan, should be first generally classified as follows:
   A. Music of solely rhythmic interest.
   B. Music of solely harmonic interest.
   C. Music of solely melodic interest.

II. Of the first group (I), each subheading (A, B, C) should then be divided into two groups each (slow, fast), as follows:
   A. Music of modal nature—slow, fast.
   B. Music of classic nature—slow, fast.
   C. Music of romantic nature—slow, fast.
   D. Music of impressionistic nature—slow, fast.
   E. Music of modern modal nature.

III. Of the second group (II), each subheading (A–E) should finally be subdivided as to key, length of piece, tempo, and character (program of absolute-music).

The repertoire of the musicians was submitted in advance and selections that were applicable to the group to be treated were made.

Records were kept on all patients and on all sessions. The session record included the name of the composition, the key, the tempo, the instrument, and the comments of the musician on the patient's reactions. The session manager also recorded on another sheet her impressions regarding each patient after every session. Between sessions the medical officers kept progress notes on patients' reactions, using the form shown on page 62.

The final evaluation was a composite of the total recorded evaluations.

At the conclusion of the first six months, a condensed report on our first one hundred cases was submitted, in accordance with a request from the Office of the Surgeon General. Representative samples of these first case histories are given in abridged form on page 63.

The period of hospitalization of all patients was so unpredictable that control cases might and often did receive transfer orders immediately after selection or long before the case under treatment had his musical sessions, and this constituted a serious drawback to an accurate evaluation.

The lack of a directing psychiatrist present at the sessions was another handicap that was keenly felt, since he would

DEPARTMENT OF APPLIED MUSIC—W. R. G. H.

Progress Notes Date .....

M. T. will chart daily the kind of music played, length of period, and patient's reaction.

Name ..... Ward .....

		M.	T.	W.	T.	F.
Initial Reaction	1. Resentful	....	....	....	....	....
	2. Sullen	....	....	....	....	....
	3. Apathetic	....	....	....	....	....
	4. Indifferent	....	....	....	....	....
	5. Apprehensive	....	....	....	....	....
	6. Anticipatory	....	....	....	....	....
	7. Interested	....	....	....	....	....
	8. Cheerful	....	....	....	....	....
	9. Excited	....	....	....	....	....
Immediate Response During Session	1. Sleeps	....	....	....	....	....
	2. Reads	....	....	....	....	....
	3. Converses with others	....	....	....	....	....
	4. Listens attentively	....	....	....	....	....
	5. Requests a piece	....	....	....	....	....
	6. Participates	....	....	....	....	....
	7. Restless, walks about	....	....	....	....	....
	8. Objects to particular pieces	....	....	....	....	....
	Changes during period: From	....	....	....	....	....
	To	....	....	....	....	....

Patient's Remarks

M. .....

T. .....

W. .....

T. .....

F. .....

have been the liaison officer between the medical department and the institute. He would have been familiar with the patients and their case histories; he would have been the person to whom the medical officers would have communicated any important information relating to patients' reactions or experiences between sessions. He would have observed patients during sessions with a trained eye, and he would have communicated silently with the musician throughout the sessions in regard to the timing of the development of the desired mood, since this timing cannot be determined *a priori*. This close coöperation between the psychiatrist and the musician would have existed not only during the sessions, but prior to them, when the musical selections to be presented were determined.

CASES FROM FIRST 100 TREATED WITH MUSIC

Age	*Diagnosis*	*Recommendation*	*Number of sessions*	*Medical evaluation*
22	Psychoneurosis, conversion hysteria	Stimulating music	16	Definitely benefited.
33	Psychoneurosis, anxiety type	Relaxation	2	Inconclusive.
21	Psychoneurosis, anxiety type	Soothing, relaxing music	8	Definite evidence of improvement shown.
21	Head injury	Soothing music	7	General sense of well-being was improved.
35	Dementia præcox, paranoid	Soothing music	14	The effect of the music on his general emotional tone was of value.
19	Dementia præcox, hebephrenic	Stimulation	7	Only objective datum was change in personal appearance. No longer had to be urged to keep himself neat.
50	Manic-depressive psychosis	Soothing music	18	Contributed to his improvement.
32	Paranoid condition	Stimulation	15	Patient's participation in appropriate music contributed to his ability to socialize.
32	Complete paralysis, median and musculocutaneous nerves, right	Relaxing music	20	Complete response with active participation.
28	Paralysis of nerves, partial	Relaxation	18	Musical therapy has been of benefit.
34	Psychoneurosis, mixed type	Relaxing music for marked tension	15	Helped to socialize.
30	Post-traumatic syndrome	Relaxing music	23	Definitely benefited.
28	Psychoneurosis	Need for stimulation	13	Derived considerable pleasure.
49	Psychoneurosis, unclassified, paranoid	Sedation	20	Sessions undoubtedly of value.
20	Psychoneurosis, conversion hysteria	Stimulation	12	Great deal of benefit derived from sessions.
20	Psychoneurosis	Stimulation	11	Active participation and expressed great interest.
22	Psychoneurosis, anxiety	Stimulation	12	Some temporary benefit.
22	Dementia præcox, hebephrenic	Stimulation	17	Benefit derived. Tendency to socialize.
27	Psychoneurosis, anxiety state	Relaxation	7	Derived much benefit. Tenseness markedly lessened.
23	Psychoneurosis, neuralgia, trigeminal, right, severe	Relaxing music	7	Beneficial effect.
27	Psychoneurosis, anxiety type	Relaxing, soothing	5	Inconclusive.
19	Psychoneurosis, anxiety type	Relaxing therapy	8	Lessening of tension to noticeable degree.

There was still another reason why the lack of a psychiatrist was deemed a handicap. It not infrequently happened that the music stirred something within patients and made those who had been silent or sullen or withdrawn suddenly begin to talk or to cry or to express other feelings. Only a psychiatrist would have been in a position to make intelligent use of these pathways into the patients' lives, and it is believed that important leads were thus lost.

In conclusion, it is hoped that this brief report of a six-month study of the rôle of music in military medicine may serve as a stimulus to further investigation and that from factual data accumulated, there may be evolved a standard method of procedure which will develop fully the potentialities of music as an aid to medicine.

REHABILITATION PROBLEMS PRESENTED BY RETURNING SERVICE MEN WHO SEEK PSYCHIATRIC HELP

MAJOR MORTON L. WADSWORTH, M.C.
Army of the United States

THIS paper deals with examples of the psychiatric problems that some returning soldiers will be presenting to social agencies, mental-hygiene clinics, and private psychiatrists. It is based upon the author's experience on the open psychiatric ward of a military station hospital in this country. Many patients were seen there who had already weathered combat experience abroad, but who had experienced an increase in their nervous symptoms after their return to the United States. Most of these patients had been assigned to the army service forces and were stationed near a large city which offered a wide range of cultural and recreational advantages. In some cases, however, their work was of a monotonous, routine nature and they missed the *esprit de corps* and friendships of their former combat units. They kept reporting to sick call with various subjective complaints and their performance of duty became so ineffective that they was hospitalized for further study.

For the purpose of this study, work sheets were prepared upon fifty consecutive admissions of patients with overseas experience. The data were obtained from the patients directly and included such details as (1) the time spent on active duty in or near the combat zone, (2) neurotic traits or behavior problems that were in evidence prior to service, and (3) the principal complaints at present.

It was discovered from these summaries that the length of time on active duty in or near the combat zones varied from a few days to twenty-two months, with the average about five months. Many of the men said that they had become "nervous and jittery" in the combat area, but had "stuck it out," while others had been hospitalized for brief periods on

account of nervousness and had then been returned to duty. Still others said that they had experienced no serious symptoms while overseas. Some had been returned to the United States because of psychoneuroses, while others, who were not considered medical problems at the time, had come back with their respective units.

Twenty-five of the patients described definite neurotic traits or serious behavior problems in their childhood. Twenty-seven men gave a family history of mild nervous disorders.

Most of the patients presented both psychosomatic and temperamental disturbances, usually with one or the other predominant. Those with pronounced psychosomatic complaints as a rule gave a history of definite neurotic traits in childhood while others with serious temperamental difficulties gave a history of having been behavior problems in early life.

The most prevalent psychosomatic symptoms that they presented were those of anxiety state with its feeling of "inner trembling," palpitation, functional gastrointestinal disturbances, headache, insomnia, feeling of nervous tension, and difficulty in concentrating upon their usual occupations and diversions. A few of them were outwardly tremulous, and many spoke of being easily startled by loud noises. Hysterical and obsessive-compulsive manifestations were met with, but were less frequent.

Temperamental disturbances were conspicuous in a considerable number. The patients spoke of their irritability, their tendencies to "fly off the handle" easily, and their desire to get off by themselves. Many carried chips on their shoulders and were quick to raise their fists in personal quarrels. Inwardly, their hearts were full of smoldering and partly suppressed antagonisms. They felt rejected by their fellows, by the army in general, and were embittered. Their disposition in many cases might be compared with that of a small child who for the time being feels dreadfully angry at his parents because they have had to deny him something. This leads the child to protest, "You don't love me, Daddy." In this situation the child momentarily hates his parent and believes that the feeling is mutual.

These patients had been frustrated in many ways, just as any one may be when he surrenders his personal freedom and comes into the armed forces. Most of their grievances,

while legitimate, were no worse than the irritations that they had met long ago as raw recruits and to which they had adjusted themselves. At the time of their admission to the hospital, they had lost the ability to laugh off their troubles and felt terribly hurt and upset by the criticisms, annoyances, and inequities incident to regimentation.

Five case illustrations are offered to indicate the range of problems presented and their relation to early behavior patterns.

Case 1.—This twenty-six-year-old private grew up in a tough neighborhood in Philadelphia. He describes his mother as a very beautiful woman, and he was griefstricken when she died. He was only ten at the time, and he and his younger brother spent the next seven years at an orphanage. During adolescence he adopted a very protective rôle toward his younger brother and was always eager to come to his assistance in a fight. He tried to be tough and felt that if you wanted to get what was your due, you had to fight for it. He was active in baseball and boxing, and any success went to his head. On returning home, he kept house for his father and older brothers by doing the cooking and housecleaning. He associated with bad companions and was finally arrested for complicity in a bookmaking scheme. He joined the Civilian Conservation Corps, but was twice dishonorably discharged for fighting and insubordination. He explains that he "just didn't like being pushed and kicked around."

At twenty-three he was drafted into the army and during his training period was court-martialed for being absent without leave. He served about a year in the South Pacific, but began to lose control of himself after the first five months. While he was guarding Japanese prisoners at Guadalcanal, one of them asked him for water and he was so bitter he wanted to shoot them all on the spot. When restrained, he flew into a rage and tore his private-first-class stripe from his arm. Later on, an attack of malaria added to his difficulties and he was evacuated to this country.

He failed to make a good adjustment at several different assignments largely because of his touchiness, his uncontrollable temper, and his unjustified feeling that he was being treated unfairly. His wife found him "a changed man." At night he would scream out in his sleep and bang his head against the bed. He drank too much and got into many fights. At home he boasted about what a good provider he would be for his family and made plans that his wife thought were much too elaborate. At other times he felt very inadequate and would come to his wife like a frightened child seeking reassurance.

As an adolescent this patient acted out his strong identification with the mother and people actually dubbed him "the lady of the house." Naturally, he felt the need of proving his manliness and did this by provoking fights and challenging the law or other symbols of authority. At the time of his induction into the army at twenty-three, he was just begin-

ning to straighten out with the helpful guidance of his older brothers. Since his return from overseas, the old conflicts have been stirred up again. He now acts out the passive side of his nature by his childish dependency upon his wife, and his aggression is expressed in his truculent, bombastic attitude towards his army superiors.

Case 2.—This is a twenty-year-old private, the son of a West Virginia coal miner. His father was a stern man who often backed up his word with a hickory stick. The mother, a very emotional woman, says she overindulged the patient because he was the first-born and a boy, and adds that he also got a good deal of petting from his three sisters. He became a behavior problem in late childhood, once tried to set fire to the house, and was often truant from school, and later adopted an openly defiant attitude toward the school principal. He entered the army directly from a Civilian Conservation Corps camp, and it wasn't long before he was court-martialed for being absent without leave twenty-three days.

He participated in the invasion of North Africa. As the first wave of troops landed, his buddy was shot dead, and he comments, "After that I didn't give a damn and I didn't care whether I got killed or not." He had been on active duty in Africa for eight months when, one day, a bomb exploded nearby, and he was brought back to the hospital in a confused, hysterical state. He improved somewhat, but became subject to recurrent hysterical seizures.

After three months in a base hospital, he was returned to the United States and spent three more months in a convalescent center. He was on his way to his first reassignment in this country when he experienced a recurrence of his symptoms and came to the hospital. He was observed in several hysterical seizures. Physically he was in good condition and an electroencephalogram was normal. He soon became a problem on the ward because of his truculence, irritability, and dissatisfied moods. He would complain that he had no friends he could trust, that the whole world was against him, and would retire to his room and refuse to speak. During interviews he confessed to a guilt feeling that he had failed to do his part in the war effort, that he was inadequate, couldn't concentrate, and went all to pieces over minor irritations.

This man's close mother and sister attachments and his open defiance of an obvious father surrogate suggest unusual difficulty with the typical conflicts of adolescence. The strain of a battle experience precipitated an acute hysterical state followed by recurrent hysterical seizures. Later on, he suffered from intense feeling states, and his behavior became more unstable. Sometimes he would be distressed by feelings of guilt and inadequacy and at other times by feelings of bitterness and persecution.

Case 3.—This twenty-three-year-old private was brought up amidst continual parental discord. His father, a chronic alcoholic, could become very abusive at home. Our patient recalls that as a child he lived in continual fear of a beating, and he also remembers his intense rage when he watched his father beat his mother. Things came to a climax in adolescence when he actually exchanged rifle shots with his father, though neither one was injured. At school he got into a good many serious fights with other boys. While a senior in high school, he was drafted into the army and has now served about three years.

After serving about a year and a half in the South Pacific, he developed his first nervous breakdown and was hospitalized with such complaints as weak, shaky spells, irritability, fatigue, headache, and tachycardia. He returned to combat duty three months later, but was less confident than before, and any loud noise would send him scurrying to a fox hole. He developed a tendency to strike people impulsively and for no apparent reason. Once it was a medical corpsman who was helping him off the field when he was stricken with malaria. Again, it was a Chinese waiter boy who was reaching over his shoulder. Nevertheless, he kept out of serious trouble and did not return to the United States until he had put in twenty-eight months of foreign service.

During his first subsequent assignment in this country, he experienced a recurrence of his old symptoms with some added features. He complained, "I don't want to be around people. I lose my temper so darn fast. I'm afraid I won't be able to hold myself back. They may be good kids, and it's not that I don't like them. Everything may be swell, and all of a sudden I want to knock them down. I'm afraid some day I am going to beat somebody half to death, and I'm afraid for them and for myself."

In spite of these fears, he never did strike any one while under our observation. As time progressed, he talked less about these fears and instead had a variety of functional gastrointestinal complaints. He was under a good deal of nervous tension and smoked three packages of cigarettes a day.

With such an unwholesome father-son relationship for the prototype of his future relationships with other men, this patient got off to a bad start in life. In adolescence he acted out the conflict by trying to shoot his father. In his relationships with other boys, he was inclined to be tough and at times mean. Far from making a good soldier, his combat experience caused him to lose confidence and become a severe psychoneurotic. The symptoms of anxiety state predominated at first. Later he showed a tendency to strike people impulsively and for no outward reason. This in turn was supplanted by a fear of people and a fear of striking them. By means of this phobia of hitting people and his consequent avoidance of people he was attempting to control his strong aggressive impulses.

Case 4.—This is a twenty-two-year-old corporal who was brought up on a West Virginia farm. His mother and oldest sister were both subject to nervous spells. As a child he was shy, avoided fights, and preferred to play by himself. Fear of the dark and enuresis persisted until the age of thirteen or fourteen. He left his father's farm to enlist in the army at eighteen and later on served about three months as a tank gunner in Africa and Sicily. In his first battle his tank caught fire, but he kept a cool head and helped the rest of the crew escape, even though it meant exposing himself to serious burns. Finding his lieutenant helpless, he pulled him across a field that was exposed to enemy fire to a point that offered protection. In recognition of this, he was awarded the Silver Star and the Purple Heart. Following this incident he was under a good deal of nervous tension, complained of palpitation, and couldn't sleep well. However, he continued at duty and participated in three more tank attacks.

After he had returned to the United States, he was assigned to military-police duty. He became increasingly dissatisfied and a frequent visitor at sick call. His psychiatric complaints increased and his working efficiency decreased to a point where he was no longer able to do a useful day's work. On admission to the hospital, he said that he could fight his illness no longer and that he had at last given up. He complained of weak, trembling sensations, palpitation, headache, poor sleep, and inability to drill or to stand on his feet for long periods. He complained that he could not adjust himself to the military-police unit, with its strict discipline and many regulations.

This man showed many neurotic traits in childhood, and it is surprising that he served so well on the field of battle. His psychoneurosis seems to have been a slow, gradual development following the battle during which he showed so much heroism. The symptoms did not become incapacitating until many months later after he had returned to this country and when, as he put it, "I could let down a little."

Case 5.—This is a thirty-two-year-old sergeant who was brought up in rural Michigan. He describes his mother as an hysterical woman who used to frighten him during her emotional episodes. As a child, he showed many neurotic traits such as sleep-walking, nightmares, and enuresis. The latter did not completely cease until the age of twenty-two. As a youth he was quick-tempered and once, when his auto wouldn't start, he threw the hand crank through the windshield. All his life he has been subject to "weak, shaky spells" when emotionally upset.

He became an aërial gunner in the army air forces and flew on a total of thirty-seven bombing missions in the Mediterranean theater. His performance was satisfactory and he demonstrated himself to be cool and capable under fire. On the thirty-eighth mission an electrical failure caused a crash landing, and though he escaped from the plane unharmed, he was in the vicinity when its cargo of bombs exploded. From that time on he was afraid of flying, became shaky, jumpy, irritable, and complained of dizziness, weakness, and nightmares. He was sent back to a convalescent center in this country and on admission he was tense,

restless, and depressed. Pentothal narcosynthesis was credited with producing some improvement, but his anxiety about flying persisted. After seven weeks at the treatment center, it was decided to send him back to duty as a maintenance mechanic. While en route to his first station, he experienced a recurrence of all his former symptoms and had to be taken off the train. On admission to our hospital he complained, "My knees are so weak I can hardly walk. My head seems to be spinning like a top, as though it were coming right off. I get pains in the neck, have a tight feeling in the stomach, my heart pounds, I get short of breath, and my face flushes."

Enuresis persisting up to the age of twenty-two is usually indicative of a deep-seated personality disturbance, and one would not have expected this soldier to make such a good showing on thirty-seven bombing missions. The precipitating event for his psychoneurosis was the plane crash, followed by bomb explosions and occurring at a time when he was being disappointed in love and when he was already tired from thirty-seven previous bombing missions. The treatment-center routine and the pentothal narcosynthesis resulted in a temporary and a partial improvement only. He quickly relapsed when faced with the task of returning to duty.

In many of these patients latent aggressive drives had been stimulated by combat experience and continued as a disturbing element in the patient's personality integration. The author believes that one of the therapist's most important functions in these cases is to assist the patients in recognizing and in learning how to control their hostile, aggressive impulses. The therapist should represent to them the good, just, and loving parent and act as a bridge by which they can reëstablish their faith in themselves and in others. Frequent individual interviews are indicated and in some cases vocational guidance and social-service assistance.

Group therapy offers interesting possibilities. Though the hospital where this study was made is not designated as a treatment center, a brief course of group therapy is offered to those who are about to be given medical discharges from the army. When free discussion is allowed, it is found that simmering antagonisms may pour forth with alacrity. This gets them into the open and lets the individual patients see that others are similarly troubled. Simply by airing their views in a psychiatric setting they can rid themselves of some of their inner tensions. This is often the first time that

these men have been able to talk frankly with a medical officer about their problems. Some of their grievances, the physician may be able to remedy. By making the patients feel his concern for their welfare, the therapist can give them the faith in their officers that will help them tolerate other frustrations that cannot be helped.

The daily activity of the group can be guided in such a way as to constitute a reëducation in finding socially acceptable outlets for their aggressive feelings. The following is an illustration of its possibilities:

A group of seventeen patients assembled and were invited to air their troubles. To start the discussion, the physician asked about a quarrel one of them had had with an attendant. Others soon joined in with tales of similar difficulties with the same attendant. The discussion spontaneously broadened until it included criticisms of nearly every phase of army life. The language became bolder and the accompanying emotion more intense. The attitude of the men was bitter and fatalistic. The physician listened attentively, interrupting only to ask further questions that would help to clarify issues. He concluded the session with a few remarks about human nature, its ambivalence, its frailties, and its contrasts of good and bad. Next he illustrated some of the socially acceptable ways we find for settling accounts or expressing our aggressiveness. He asked every one to read *Joe Is Home Now,* an article on page 68 of the issue of *Life Magazine* for July 3, 1944. It describes the emotional difficulties of a returned service man.

This article was made the subject of discussion during the next meeting. Joe had almost come to blows when his right to wear his campaign ribbons had been challenged by a stranger. Many in the group had had similar difficulties and had found it hard to restrain their wrath. These ribbons may sometimes be purchased at retail stores without presentation of the proper credentials, and there is widespread feeling that some soldiers display them who are not entitled to the honor. Consequently, especially when soldiers are drinking, the wearer of ribbons is often challenged and a fist fight ensues. In the discussion several of the patients complained that they had never been given any credentials to prove their right to campaign ribbons. The physician met this problem

directly by arranging for the hospital authorities to provide each man with an appropriate letter certifying to his eligibility to wear certain ribbons.

During the same hour a request came from the patients that they be allowed to make purchases at a post exchange located outside the hospital bounds. They were informed that this was against the hospital regulations, and all accepted it without any apparent resentment.

At the next meeting one patient expressed resentment because he had been moved out of his private room into the open ward to make space for some one else. The physician explained that each floor had six private rooms with bath and a twelve-bed ward. He told the group that on their floor there were no medical indications for private rooms, that they were just an added luxury, and that the group could decide for itself how they should be apportioned. The most constructive suggestions came from the individual who had been most vehement and most caustic in his criticisms of the army at the first meeting. He suggested that the six patients who had been on the wards the longest be given the rooms, and that as they were discharged, others take their places in order of seniority. The group accepted this plan, and he was asked to draw up a roster. A friendly spirit prevailed on the ward and a very difficult patient became a dependable assistant to the nurse.

It is not implied that these group meetings profoundly alter the patient's attitude in a short time, but they do illustrate how group acivities can be guided in such a way as to help these men with their specific problems.

MARRIAGE PREPARATION MUST BE MODERNIZED

HENRY BOWMAN

Stephens College, Columbia, Missouri

ALMOST any one may get married. All one needs are a desire to do so, a prospective spouse, some one to officiate at the ceremony, and a dollar or two for a license, as if one were buying a dog license. Yet we have the temerity to say, "Whom God hath joined together let not man put asunder."

We talk glibly about the sanctity of the home. We call the family the bulwark of civilization. We ruefully regret the rising divorce rate and zealously oppose easy divorce. Yet we put few safeguards around entrance into marriage. We permit people to marry in haste, only to repent at leisure—and often in misery.

Two service men were walking down a side street at about 7:00 P.M. In front of a restaurant they met a girl and the three went inside for food. While they ate, something stirred in the heart of one of the boys. It must be love, he thought, and mentioned it to the girl. Something was going on inside her, too. They decided to get married; and by 10:30 P.M. they were man and wife. The next day the boy was "shipped."

A boy and girl met at a dance and were attracted to each other. After the dance the group went to a downtown restaurant for food. All went in cars except this couple, who decided to walk. By the time they reached the restaurant, they were married.

A bucking horse threw a rodeo performer into the grand stand, and he landed on the lap of an attractive young woman. Three days later they were married.

A service man saw a girl's picture in a newspaper. He wrote to her and they started corresponding. By correspondence they fell in love and by correspondence they became engaged. On his first leave he visited her. They met on Wednesday. On Thursday they were married.

Extreme cases? Perhaps. But not uncommon cases. And all legal.

In some states a girl is permitted to marry so early that she may not have reached puberty, certainly not the age of safe child-bearing; she is not permitted to vote; she cannot sign a valid contract; she may not leave school; she may not get a work permit. The assumption seems to be that marriage requires less maturity than these other things.

This is an atrocious situation and legislators are partly to blame for it. What about educators? Are they any better? Not that they want young people to marry poorly. But often they do so little to help them marry well. Many educators have been inclined to take a hands-off attitude. Many expect young people to face problems in this modern, complex, streamlined age with T-model equipment picked up helter-skelter as they struggle unguided through the throes of adolescence. With marriage, homemaking, and parenthood putting new demands upon young people, they are too often left to get preparation as did their grandparents when times and demands were quite different.

Successful marriage is not something that comes full blown out of the clear blue to every one who has a romantic impulse. It is not a gift of nature offered free to any one who will but pluck it lazily from an uncultivated vine. It is not natural at all; it is artificial, just as any work of art is artificial. There is no instinct to guide young people; marriage is more than animal mating. There is no divine revelation. No oracle speaks on the wedding day. There is no pillar of cloud by day or pillar of fire by night to guide young wanderers in the marital wilderness. Successful marriage requires effort, is based on sound knowledge, and is grounded in solid idealism. These suggest preparation. They cannot safely be left to chance or camouflaged by blind hope.

A recent article discusses "odd courses" taught in schools. It mentions a course for school janitors, courses in piano tuning, fresh-water fishing, coaching a baseball team, how to relax, mountaineering, and marriage. Another decries modern education and, with a sweeping gesture of depreciation, classes a course in preparation for marriage with one on how to drive a car.

Such articles are not common, but they do reflect the atti-

tudes of a considerable portion of the population, both lay and professional. Such attitudes grow out of a lack of knowledge of the needs of young people and a lack of understanding as to what courses in preparation for marriage are attempting to accomplish. These courses are not publicity stunts. They are not superficial "leaders" to attract students. They are not directed solely toward student interests. They are sincere attempts to meet a basic need.

Unfavorable criticism of marriage education also grows out of the common tendency to fear what is new. Automobiles, airplanes, daylight-saving time, vaccination for smallpox, education for women, anæsthesia during childbirth, a thousand and one other things now taken for granted were at first opposed because they deviated from the traditional and customary. Many a pioneer has been called a fool because he tried something, went somewhere, formulated some idea, or discovered some fact that upset the complacent stagnation of his contemporaries who lacked perception, foresight, or courage. If new ideas and methods in education are to be relegated to the category of the inane even before they have been sufficiently tested, how can we ever expect progress? How can such a procedure be justified in the light of history, which records the struggle of ideas and ideals and shows man in his better moments laboriously trudging the path of enlightenment, with the weight of tradition, prejudice, and blind conservatism dragging at his heels?

By and large educators teach what they believe students need. Sometimes, however, they misinterpret or overlook certain needs. We do a good deal to meet the intellectual and cultural needs of students. But for every student who needs to know how Cæsar planned his campaign in Gaul, there are hundreds who need to know how to plan a successful marriage. For one who needs to know something about cosines and quadratic equations, there are hundreds who need to know something about co-partners and a personal equation involving two variables. For one who needs to know the conjugation of foreign verbs, there are hundreds who need to know something about conjugal relations. For one who needs to know the reactions of an amœba, there

are hundreds who need to know the reactions of a husband and wife.

This is not meant to imply that Latin, mathematics, modern language, biology, are unimportant. But are they more important than marriage? One is reminded of the high-school boy who, upon graduation, remarked that he had learned a great deal to prepare him to become a Roman emperor, but not much to prepare him to become a husband.

We do a good deal to meet the vocational needs of students. Yet we permit young people to enter marriage with preparation so meager that, if they had only an equivalent amount vocationally, they could not last a week in a business office or get to first base in a profession.

We do a good deal to meet the social needs of students, in both the societal and the extracurricular sense. At the same time that students are making choices of friends, vocations, avocations, and academic subjects, they are making choices that will finally play a part in the selection of husband or wife. Young people have many questions about marriage. Whose responsibility is it to help them answer these questions? As it is now in many school systems, they must go to almost any one but their teachers, or else go to their teachers in out-of-class hours to seek their help in an unofficial capacity. It should be possible for them to get the assistance of qualified instructors who are members of the regular staff and whose offerings are a recognized part of the curriculum with the same status and prestige accorded other subjects.

Instances that dramatize the need of education for marriage continually come to light. A girl of high intelligence and unusual beauty dropped out of college, jilted her student fiancé, and married an uneducated mechanic. After living with her husband for five years and bearing him three children, she obtained a divorce and married the first man, who had waited. But readjustment was impossible and a second divorce was applied for within two months of the wedding. A minister with several degrees, who exhibits fine ability and outstanding courage in the pulpit and is respected by his parishioners, is faced with defeat and failure in his marriage because he is still tied to his mother's apron

strings. A teacher with a college degree has hysterics during her premarital medical examination. A young woman in the final year of professional school is jeopardizing the success of her marriage by her complete ignorance of the A B C's of anatomy. These persons, and innumerable others like them, pay fees at counseling agencies to fill in the great gaps left by the schools in which they received their supposedly adequate formal education.

Letters from scores of persons seeking, not advice to the lovelorn of the snap-judgment type, but sound information by means of which they may solve their problems, or enter marriage better prepared, testify to this same general need for marriage education. A few excerpts from such letters suggest the usual tone.

From a young woman who is aware of the need for more information:

> "I am a housewife eighteen years old and have been married eight months. We did not have a course in marriage in my high school. My parents never told me anything about marriage and what little I know I read. They were very strict, too, and never allowed me to go with more than one boy. Naturally it led to marriage. I married knowing nothing of the function of marriage. I only wish I could be in a class where such problems are discussed."

From a middle-aged woman:

> "I have been married twenty-two years and am the mother of six children. My marriage has gone on the rocks. My husband and I are on the verge of separation caused by ignorance. I am only forty years old, but there seems nothing left to live for. My twenty-one-year-old son is planning to get married. He is just as ignorant about marriage and its responsibilities as I was."

From a college graduate:

> "This spring I was so unfortunate as to graduate from a school which had no course in preparation for marriage and evidently no thought of ever organizing one. I am to be married next summer and I do not plan to enter marriage without sufficient knowledge of the major problems which face a newly wedded couple. I want to compensate for the lacks in my education."

From a disillusioned young man:

> "If I had had a chance to take a marriage course, I would not now be recovering from a nervous smash-up due to the failure of my own marriage. I am thinking of that great mass of young people who never get as far as college and who fall by the wayside in public school, but who need this valuable education as much as college graduates. How can preparation for marriage be carried to them?"

From a student in a professional school:

> "I have puzzled for two years over every problem I have ever heard could wreck a marriage and every one seems to apply to my own case. For two years I have fought a growing certainty of failure in marriage, knowing always that my own pessimism was the surest guarantee of such failure. And yet every time I fought through to a moment's optimism, a casual remark from some cynical wife would throw me back into the same old hopelessness. There are so many cynical wives! I have never in my life, so far as I can remember, heard one married woman say that she was glad to be married, that she thanked her lucky stars for her wedding day, even that she had found marriage other than mildly repulsive or worse. Yet every time I turn around I hear half a dozen wives testifying to their disillusionment. Things like that tend to be slightly discouraging. So here I am, after two years of being engaged, about as anxious to be married as I am to be hanged, and yet, amazingly enough, very much in love with the finest boy I have ever known."

Cases similar to these are legion. They may be found in every community and school group in the country. They testify undeniably to a universal need of education for marriage, a need that cannot be met save through sound educational procedure. Sometimes students are several jumps ahead of teachers in recognizing this need. Everywhere they have begun to express their awareness of the need of education for marriage. In continually increasing numbers they are looking to their teachers for the preparation they realize they should have. One hopeful thing about this somewhat confused modern age is that so many young people are demanding information about marriage with some expectation of getting it.

Student awareness of need is also indicated by responses on inquiry forms. When more than a thousand college girls were asked to state what they considered to be the best way to prepare for marriage, their replies showed that the great majority (96 per cent) recognized the need for instruction in the area of marriage relationships. They were not all agreed as to the best means of obtaining this instruction, but there was a definite and obvious preference for a regular course supplemented by good reading. A considerable number of girls (69 per cent) had found their parents helpful, but still felt the need of a course. Some who felt the need for instruction felt that they could not turn to their parents for assistance. Still fewer (49 per cent) thought that it was helpful to talk with friends their own age. Only 41 per cent

would turn to their teachers (in courses other than the marriage course) for information about a subject on which they almost unanimously agreed that they needed information. Since these girls had been in schools of one sort or another for some twelve or thirteen years, this attitude toward teachers is thought-provoking.

Forty-six girls (4½ per cent) felt that the best way to prepare for marriage was to remain ignorant, and gave three arguments for their statements. These girls present an interesting, though somewhat startling, picture. They reflect an all-too-common traditional obscurantism, the heavy hand of which has tended to retard the development of marriage education. They were only forty-six, but that number will fill a good-sized classroom. How mistaken they were! How disillusioned they will be when they discover that what they need to know will not come to them like manna from heaven! These are the very girls most in need of education for marriage. Their unawareness of this fact serves only to accentuate their need.

The three arguments that they gave are three of the commonest arguments against marriage education. Some girls said that a study of marriage operates to destroy romance. This is a misconception. There is a tendency for some young people to want to fall in love blindly and, like the proverbial ostrich, put their heads into the sand and close their eyes to those parts of reality which may eventually work together for their misfortune. There is also a tendency in this country to overemphasize premarital romance and glamour as if these were guarantees of happy marriage. This overemphasis on premarital romance is common in the press, in the movies, and in modern literature. It serves only to make it easier for young people to choose the path of least resistance and think only up to, rather than beyond, the wedding. Divorce statistics do not show that "they married and lived happily ever after."

The second argument that "there are things no girl should know before marriage" is an outgrowth of our traditional obscurantism. Let us agree that there are some things no girl should *experience* before marriage. But this is not the same as saying there are some things she should not *know*. Ignorance may be bliss when there are no prob-

lems to be solved. But the moment that problems impose themselves upon existence, ignorance becomes a contributor to disillusionment, disappointment, and defeat. All marriages, even the best ones, involve problems. It is inconceivable that a girl who lacks knowledge can solve them better than a girl who understands them. It is unbelievable that a girl who carries into her marriage distorted ideas, fears, and inhibitions is in a more favorable position than the girl who has had her distorted ideas straightened out, her fears removed, and her inhibitions replaced by intelligent control.

The last argument that "there is plenty of time after the wedding to learn what one needs to know" is unsound. If there is plenty of time after the wedding to gain an understanding of marriage, why do not the thousands of couples who get divorces, and the additional thousands who continue to live together after their marriages have failed, complete their marital education? There is no other area of life where such a short-sighted policy is advocated. We do not say, "Wait until you get a job. There is plenty of time after you get one to learn what is necessary to make it successful"; or, "Wait until you are sick to study hygiene"; or, "Wait until you are a voter before you study government"; or, "Wait until you have an income of your own before you make a study of budgeting." Marriage is the only human endeavor in which ignorance is considered a virtue. In marriage there is no period of grace during which there is a moratorium on problems so that newlyweds may complete their education. Problems become imminent the moment the minister says, "I pronounce you man and wife." If problems customarily waited to make their appearance until the couple had been married a few years, the above argument would have weight. Many a marriage is permanently injured during the first few weeks after the wedding.

But progress in the development of marriage education is being made. Much good work is already being done. The ball has started rolling. Preparation for marriage is gradually coming to be recognized by students, teachers, and parents as a vital, essential part of the general educational process. It is slowly achieving status; and one by one the arguments of its critics are being answered. We may with

confidence look forward to the day when a school that omits education for marriage from its curriculum will be looked at in the same light as a school that now omits psychology or sociology, refuses to admit that some good literature has been produced since the nineteenth century, or prohibits the teaching of certain phases of natural science. All of life is preparation, good or bad, for marriage. If schools do not provide education for marriage that is good, young people cannot be blamed for relying upon that which is bad—and the divorce rate will continue to skyrocket.

PSYCHIATRIC CASE-WORK COUNSELING IN COMMUNITY CENTERS

WILLIAM KATZ

Jewish Board of Guardians, New York City

THE material in this paper arose from a project started about eighteen months ago by the Jewish Board of Guardians and a number of New York community centers. The staffs of the centers were increasingly feeling the pressure of handling children with difficult behavior—behavior that sometimes upset the group procedures. Group leaders felt challenged by the atypical child, and were seeking help either in handling him in the group or in making the necessary treatment available.

The project involved the assignment of a psychiatric case-worker for a stipulated time weekly to a community center. His purpose was to help the staff in handling children who were not adjusting adequately and in recognizing symptoms of personality difficulty, and, where necessary, to help the child toward treatment resources.

A major aspect of this counseling work was the interpretation of mental-hygiene concepts to group workers.

Actually, since group workers deal with people, they, like teachers, nurses, or case-workers, should be equipped with a knowledge and an acceptance of basic mental-hygiene principles. The differences in the use of these principles depends only upon the variations in the nature and purpose of the relationship to people within these professions.

The basic mental-hygiene concepts, of which all who deal with people in a helpful relationship should be aware, can be summarized briefly as follows:

1. Patterns of behavior toward parents, teachers, other children, or group workers are determined by the individual's experiences in his early formative years.

2. Every child needs love, security, and a sense of being wanted.

3. Every child needs the chance to grow, and to be independent and respected within the limits of his capacities.

4. All behavior has a reason and a purpose for the individual in meeting his task of coping with daily life. These concepts are a guide toward understanding behavior in a noncritical, objective manner and toward "individualizing" a child's problems by scientific study. Only in this way can adequate plans be made to give the child the satisfaction needed for normal growth.

Although most group workers are familiar with these basic mental-hygiene principles, the case-work consultant can offer valuable service in interpreting them so that they can be more fully comprehended and integrated into the daily job performance and be used sensitively and constructively for the benefit of the children concerned. The counseling service, through its educational implications, may, in some instances, increase the breadth of a group worker's knowledge, but it is more important that it increase its depth, since with depth comes more sympathetic understanding. This is the value of the counseling project in interpreting mental-hygiene concepts.

As in any learning experience, both emotional and intellectual factors are involved in the interpretative process. Group workers, who have been faced in recent years with increasingly serious behavior problems among their children, and have grown to feel more and more impotent and frustrated over their helplessness in meeting these situations, welcomed the case-work consultant as some one who would deepen their understanding of individual behavior and assist them in formulating plans to help children within the group setting. Yet while they turned to the case-worker for constructive help, there was also a defensiveness over revealing their own inadequacies and a feeling of threat to their own professional capacities.

At the beginning of the counseling service, there was a marked tendency toward an overevaluation of the "child-guidance expert." There was a kind of naïve expectation that the case-worker would wave his "fine Havana wand," pronounce a few magic words of easy advice, and all harassing behavior problems among the children would disap-

pear. At the same time, there was a defensive contempt for "fancy psychiatry" when the case-worker could not meet, and even refused to attempt to meet, such unrealistic expectations. Often this attitude was expressed in such remarks as, "Don't ask me to figure out that child. I'm not trained like you. You go into the club room and take a look at him. Then come back and see if you can tell me what's wrong with him and what I should do." This attitude was a serious block to a mutual coöperation and integration of skills between the group worker and the case-worker. The handling of this was in itself an important interpretative process.

This attitude stemmed out of a certain confusion about function which I have found common among both group workers and case-workers. This is the belief that both fields have the same professional source. It is true that case-work and group work have the same aim of helping the individual toward a more comfortable adjustment to society. But so do teachers and psychoanalysts, yet we do not think of them as having the same functional orientation. The group worker is primarily an educator helping normal children in a group relationship to enjoy the use of creative, recreational opportunities in crafts, social clubs, or other activities. The psychiatric case-worker, on the other hand, is a therapist helping, in an individual relationship, pathological children who, because of emotional distortions reflected in behavior, either are not able to make constructive use of such recreational opportunities themselves or interfere with the enjoyment of other children. The concern of the group worker is with normality; the case-worker deals with pathology.

Although the pressure of the problems of social maladjustment among adolescents has created confusion to the contrary, the settlement house, the "Y," or the community center is designed for normal, or average, behavior; it is not a clinic. If this distinction is clearly understood, then the group worker need no longer feel insecure, or suffer from a sense of failure, because of inability to deal with the pathological among a group of average children. It means that the group worker can face the case-worker secure in the area of his own special competence and with no need to expect too much or too little of the case-worker. It means

that the two can begin to use their skills coöperatively in planning for a child in a mutually responsible fashion. The group worker can share comfortably in the case-worker's problem of understanding difficult behavior and, with recognition of the limitations and capacities of the case-worker, can come also a more sensitive understanding of the realistic complexities of child behavior.

In many of the children brought to my attention, pathology was so severe as to require specialized child-guidance services outside of the group-work setting. It has been unfortunate that the pressure of the large numbers of these children has meant that most of my time was devoted to discussion of severe pathology. Even such cases, however, can high-light problems that can be used to further understanding of the emotional needs of all children and to give impetus, through keener awareness of the dynamics of personal relationships, toward a more meaningful handling of children in groups.

Tony, one of the children brought to my attention, was a tall, thin, awkward boy who seemed to be the leader in any destructive activity. He was active, restless, and usually aimlessly grinning. It was noticed that when he was not active, his face had a sad, withdrawn look. Because this boy really was a case for a child-guidance agency, I do not wish to go into any further elaboration of his history or pathology, except to say that in the course of my contact with him, I concluded, among other things, that he was basically an extremely insecure adolescent, with no confidence in his capacity to be liked, or to meet young manhood with the degree of adequacy he expected of himself. What seemed antisocial conduct was in reality only the frightened behavior of a boy clutching at the straw of masculinity that he expected would be snatched away from him in any case. Yet the group workers who knew him interpreted his behavior as destructive hostility and reacted with equal violence, and, unfortunately, their reactions were often no more adult than Tony's.

His behavior was particularly annoying at the weekly social dances given at the center. For example, on one such evening he was engaging in some characteristic cutting up. He danced with another boy, acting as the female partner, drawing laughter from some by his impersonations, but annoy-

ing those whom he jostled on the dance floor. He made suggestive remarks to girls. He was ordered off the floor by one of the staff, and a few minutes later was creating further disturbance by starting a wrestling match in a corner with one of his friends, in the course of which chairs were being broken.

In discussions with the staff, I pointed out some of the underlying meanings I have suggested for this boy's behavior. Specifically, in regard to his behavior at the dances, I suggested that Tony acted as he did because he really did not know how, or think that he was able, to use a dance constructively. He was doubtful of his adequacy with girls and expected to be rejected. I also suggested the probability of a good deal of adolescent sexual conflict. Far from seeing his behavior as inherently vicious, I suggested that Tony was indulging in infantile methods of covering up real fears about his masculinity by a pseudo-masculine pose of aggressiveness. Tony needed to be encouraged to believe that he really could be like other boys. To punish him for his behavior only increased his belief that he was inadequate and could not be accepted. Perhaps it also stimulated his guilt over his adolescent sexual drives. Tony really did want to be like other children at the dance, but he did not know how. He was not the tough, dare-devil fellow he tried to make out. He might be fooling the group workers, but he would really prefer to be understood.

There was a marked change in attitude toward Tony by the staff after this discussion. He was accepted in more friendly and tolerant fashion and there was less reaction to his surface behavior. With increased understanding, one of the women group workers, instead of yelling at Tony when he misbehaved at the next dance, invited him to dance with her. She was not unprepared, as she might have been without our discussion, when Tony bashfully and timidly rejected her invitation because he did not know how to dance. She sympathetically offered to teach him.

Soon Tony was dancing at dances, first with other group workers and later with girls his own age. Tony's attitude toward the group-work center changed to such an extent that I myself was surprised to hear him yell at a boy who in

horse-play had broken a chair, "Quit that, you jerk! Would you do that in your mother's house?" On the whole, progress with Tony was not all as successful as this, but the insight gained out of this experience into the underlying dynamics of human behavior was constructively used by the group workers in other instances also.

With such insight, group workers really began to understand the meaning of the concept that the early years of a child's life form the pattern of future behavior. They began to understand how a child who felt rejected at home—and, therefore, saw no reason to curb his instinctual behavior in a hostile world—would carry this attitude over into the group-work center just as he would to school, for example. It was pointed out that to meet such a child with further criticism or hostility only confirmed his feelings of rejection. While it was not within the province of the group workers to give the child the intensive attention necessary to correct his view of society, they could, by a sympathetic awareness, avoid giving him further confirmation of rejection through their reaction to his behavior.

Often group workers who accepted this concept intellectually would, without being aware of it, stimulate the aggressiveness of the children they handled. In one group, which was often disturbed by the disruptive "wisecracks" of one of the members, the leader would "wisecrack" back. Soon the whole group would disintegrate in unruly behavior. The leader explained to me that he did not want to be harsh with the boy, who he knew was deprived, and so he thought he would "kid" him out of his behavior. It was possible to give this leader credit for his good intentions and at the same time to show him the critical and hostile implications of his method, and how it stimulated retaliatory behavior. In another case, a group worker became able to understand that her having warned a boy who had a reputation for misbehavior, but who, at the moment, was behaving well, that he "better keep on being good" was at least one precipitating factor in arousing the wild and destructive conduct that occurred within a half hour.

The group workers began to understand the development of antisocial behavior and to realize that such behavior was

not necessarily a personal attack on them, but often was only a symbolic representation of some deeper unhappiness. Sometimes even the personal experiences of a group worker could be used, through identification, to elaborate the concepts of child behavior.

A group worker asked my advice in friendly fashion about a personal problem she was facing. I did not go into this, but from what she told me, I was able to show her that the specific problem raised for discussion was only the surface reflection of a more serious and significant conflict underneath; it was this that was really bothering her. In fact, she was not asking for my advice on the question she had raised, but on this deeper problem. The group worker grasped this with quick insight. I then used this experience to illustrate how the surface behavior of children reflected a deeper involvement. Just as it might have been destructive for her to react to her surface question without understanding the deeper one, so it may be destructive to react to the surface behavior of a child without knowing why he acts as he does and understanding the underlying meaning of this behavior.

A natural result of this increased understanding of the group workers for their children was that many began to feel more friendly and secure with children who formerly had been only annoyances.

Some of the activity leaders in the neighborhood center revealed what I have termed for lack of a better name the "art for art's sake" approach to their work. I refer to that kind of attitude which sees itself only as teaching a certain skill, such as woodwork or dramatics, and is perturbed by the child who is awkward at his tasks, despite evident enjoyment and regular attendance.

One boy annoyed a leader by the clumsy way he handled tools. In a spirit of helpfulness, this leader was continually criticizing, teaching, or doing the actual work himself for the boy.

Since this boy was a dull child, under my observation because of aimless, attention-seeking behavior, I discussed with the leader the child's need to find satisfaction in some kind of manual activity. The boy had a history of never sticking long at any activity, and I pointed out how the

leader's attitude merely gave him an increased sense of his own inadequacy which would soon drive him out of this activity, too.

The leader retorted that to him a tool was not to be used inefficiently. I agreed, but replied that a tool in a settlement house was not to be used to make a craftsman, but to give a child an opportunity for emotional satisfaction through creative activity. This was the real meaning of giving a child respect and a chance to grow.

When the leader was skeptical, maintaining that there was no satisfaction without skill, I advised him to praise the boy's work as much as possible, or at least to ignore his awkwardness, and see what would happen.

When the boy finally finished whatever he was making, even the leader was impressed, since this was the first time in three years that George had ever completed anything. When the boy began new projects with increased enthusiasm and self-confidence, this leader began to have a new concept of the value of his relationship to the children.

There are dangers that should not be overlooked in interpreting mental-hygiene concepts to group workers. It must be remembered that the counseling project represents continuous experimentation in a new area for the case-worker, and methods and criteria have still to be developed. Out of the mistakes that have been made, some of the pitfalls to be avoided can be ascertained. The case-worker must confine his attention to the individual child and allow the group worker, with the increased understanding he has gained, to determine specifically how the child can best be dealt with in relation to the whole group. Case-work techniques that are valid in the handling of pathological children in an individual-treatment relationship cannot be applied to a group situation with essentially normal children. As case-workers, we are all familiar with the teacher who tells us that she cannot give extra attention or freedom of action to the one child we are treating at the office since it would disturb the entire class. Interpretations must not be given loosely, and psychiatric "lingo" must be avoided. Loose discussion, wrongly understood, may lead to action destructive for the child.

Many group workers have found their work more interesting and challenging as their understanding of child behavior has deepened. Most group workers are "giving" to normal children. It is when the child deviates from the normal—whether because of some temporary frustration or as a result of deep personality conflict—that the group worker is inclined to feel threatened or hostile and to react negatively. As the group worker becomes more secure in his grasp of the underlying meanings of behavior, there is a lessened tendency to react on a personal, superficial level and a greater awareness of the wider implications, both of his professional responsibilities and of the values he offers children.

The counseling project has helped the group worker, already possessed of good intuitive capacities, to develop a more disciplined understanding of children; and it has stimulated further sensitivity for the group worker in his function of helping children to meet normally the usual frustations of life through satisfying sublimatory activities. It is hoped that the knowledge and experience derived from the counseling project may also be a factor encouraging the growth of the kind of scientific curiosity and morale that will foster the development of more professional standards in group work.

INSTITUTION OR FOSTER HOME?

FRANK M. HOWARD

Executive Secretary, Children's Service League of Sangamon County, Springfield, Illinois

AFTER the breakdown, about seventy-five years ago, of the almshouse methods of caring for dependent and neglected children in this country, there was a marked development of two methods of caring for children who, for any reason, must live away from their own homes and families. One was foster-home care and the other institutional care. It is highly unfortunate for the children involved that these two methods, despite the fact that both had the same high purpose of helping these children, grew up and developed as two completely separate philosophies.

In recent years more effort has been made to bring these fields closer together, a healthy sign that at long last we are facing the truth—that our mutual interests and problems are very closely related, and in many cases identical. These are not two fields of work, but one field, and this fact must be recognized by both groups if we are to meet the increasingly complex and difficult needs of children to-day.

Let us look for a moment at some of the problems we face. During the past twenty-five years we have learned a great deal about children. The psychologists and the psychiatrists have given us a new method of understanding people which has brought to light many problems and confusions within some children. These problems have existed within the children of all times, but it is only in comparatively recent days that we have been aware of them. The recognition of these problems brings with it the necessity of doing something about them.

I believe, however, that to-day, in addition to discovering these old problems, we are facing new ones. Formerly, children were sent to child-placement agencies and institutions because of poverty or because of the loss of one or both parents. Many of these were quite well-adjusted children who, at least in their early years, had enjoyed security in

the affectional bonds of the family. Fortunately for these children, advances in our social thinking have allowed them to remain in their family circles. The children who now must be removed from their homes are much more gravely injured by life. There has seemed to be a serious increase in family problems, with many more families breaking down under the strain of the social complexities of modern life. Particularly now, with the added stresses of the war, we find growing numbers of families breaking up around the children, and we can expect this tendency to increase. We know that the end of the war is going to bring with it weighty problems of social adjustment, and that we must prepare ourselves to meet an increasing number of family breakdowns during the post-war period.

Under these conditions, we find seriously confused and disorganized children. No longer can the placement agency or the institution meet their problems by furnishing good physical care, a good educational program, and careful basic training. The children we see to-day are in need, not of an opportunity to continue their development as already started, but rather of strong, skillful help in meeting the problems they are facing. The only way we can give this is for all concerned in dealing with them to work closely together, pooling their services and using the highest skills that they possess.

It is important that we not only continue, but increase our efforts to keep as many children as possible within their own family groups. If it is possible for the child's problems to be worked out in his own family situation, we must make every effort to do this. Those of us who are working with children away from their own homes realize that placement, either foster home or institutional, is a highly traumatic experience and one to be avoided, if possible. Perhaps our war-time shortages of foster homes and of institutional staffs will force us to develop greater skill in helping children within the family, much to the benefit of these children. There are, however, situations in which, despite the traumatic damage placement causes, it is less than the damage done to the child if he remains at home. Then we must bring our highest skills to bear.

The basic skill that we have a right to expect from any

agency, foster home or institutional, that is working with children, is a real understanding of these children and of their individual emotional and social situations, and a carefully thought out and practical philosophy of helping them solve their problems.

After determining that removal from the home is necessary, one of the first questions for the placement worker is, What are the needs of this child, and what type of placement will best meet them? For too many years, the agencies that use foster homes have gone on the premise that every child that comes to them needs foster-home care. The institutional people have been equally guilty of thinking that every child should be placed in an institution. Some placement agencies, however, have, during the past few years, been facing more and more the fact that some of the children under their care cannot be helped in foster homes, but that institutions or schools can offer what the child needs.

The first question the worker must answer, then, is whether the particular child in question can best be helped in a foster home or by placement in a group. The second question, if it is to be a group placement, is which institution or school. There are vast differences in institutions. Much as we may hate to admit it, some institutions are undoubtedly so poorly set up, and have such a poor philosophy of child training, that we can consider them as harmful to the children placed in them. Others may be very helpful to one child, but definitely harmful to another. Probably no one institution is suitable for indiscriminate use by an agency, any more than one foster home can handle the problems of all types of child. There is a tendency to believe that because the school is an established institution, set up to care for children, it should be accepted at its own evaluation. This is, of course, a very naïve attitude. Placement in institutions calls for just as careful investigation of the school as we give the foster home, and the selection of the right school for the individual calls for careful diagnosis of the child's needs and evaluation of how the individual institution can meet them.

What are some of the basic services the placement agency has a right to expect from an institution?

1. An adequate physical plant.

2. An understanding of the physical, educational, and emotional needs of the individual child and a philosophy and program fitted to meet these needs.

3. An intake program based on a realistic evaluation of the service the institution can offer.

4. Sufficient staff to handle the group and to give attention to the individual child. We have a right to expect that this staff will be well trained, either before they come to the institution or within the institution, and that they be people who are themselves reasonably well adjusted and secure in their personal lives.

5. Sufficient flexibility to meet the needs of the children in the group. This means flexibility of the general program to meet the needs of the group as it is composed at any time, so that the program will fit the group instead of the group's being forced to fit the program. We recognize the fact that one of the necessities, and one of the values, of group living is that the group comes first in our consideration. But we also have a right to expect that this consideration of the group be based upon the welfare of the individuals that make up the group, and that the program be sufficiently flexible so that on occasion a certain child's individual needs may take precedence over the needs of the group as a whole.

6. A discharge policy based on the child's readiness for release. To us in the foster-home field, it often seems that the institution is reluctant to release children when we feel that a new placement, or a return home, is indicated.

The institution, on the other hand, has a right to expect certain things from the placement agency. In the first place, it should expect a complete and honest investigation and evaluation of the child referred. That statement may carry serious implications, but institutional people can tell of many cases in which agencies that wish to see the child placed in a certain school have "forgotten to mention" facts that they felt might lead to a rejection by the institution. This may mean that the institution accepts a child whom it is not prepared to serve, or that it will find out these facts about the child after he has been in residence for some time and when it is less well able to deal with them. Such a procedure certainly does not work out for the welfare of the child or help to further respect and coöperation between the agency and the institution. The institution has a right to expect that the worker will understand the problems and philosophy of the institution and will coöperate with it.

Now to return to the first question we raised for the worker in the placement agency—which child needs foster-home care

and which institutional care? We must recognize the fact that we are working with individuals who present a wide range of difficulties and a variety of problems or combinations of problems. We cannot set up a definite classification and say that all children of this type need one treatment plan and all of another type some other. The question must always be determined on a case-work basis to meet the peculiar needs of the particular child. I cannot, therefore, attempt to answer the question, but can only point out some of the general things that we have learned from our experience and some of the thinking that goes into our placements, particularly school placements, at the present time. There is need for considerable thought by placement workers and institutional people together on this problem.

I think we are justified in making the general statement that foster-home care is nearly always the best thing for the younger child—that is, the child up to adolescence. One exception to this is probably the child who shows such peculiar or difficult behavior that the foster home cannot stand up under it, or the child who is a menace in the community and needs special supervision.

Another group of younger children whom we see in increasing numbers are those from good homes who are in need of short-time care, but who will eventually return to their own well-adjusted homes—children whose fathers are in the service and whose mothers are working, or whose homes are temporarily broken up by the war or for some other reason. When these children can receive their real emotional security from their families, I suspect it may be better to put them in a group, where they can be well taken care of without any strong affectional demands being made on them. In the foster home, where the foster parents expect an emotional response from the child, a serious and harmful conflict may be set up for the child.

Perhaps this reasoning can be extended to another group. We see children who have strong ties to their family, or to some member of the family. Sometimes these are healthy ties that should be preserved, yet the child must be out of the home for a long period. If family ties can give to the child the feeling of security and affection that he so greatly needs and that is so basic to his future welfare, can this not

be better preserved in the less personal atmosphere of the school than in a foster home in which there are opposing affectional pulls through the very fact of living closely with the foster parents? There is danger, however, in such a placement, unless the school can give the child sufficient freedom to avoid regimentation and too narrow a life experience.

Probably there will be other exceptions, but they will be rare. Aside from these situations, we recognize the need in the younger child for an affection and an identification with parents or substitute parents that can be found only in the child's own home or in a foster home. It is through this affectional tie and identification that the child develops and grows into adulthood. In the group these children have no one to tie to directly and must share the adults with many other children, and so are in danger of developing a pattern that will never permit them to establish other than superficial relationships with people. We see this same reaction among children who are moved from foster home to foster home without staying in any one long enough to form real ties. The young child's personality is not yet developed and in a school he easily becomes regimented and institutionalized.

By the time a child reaches adolescence, however, he has gone through these early identifications and is beginning to attempt to make a life of his own. It is the time when he normally loosens the closer ties of the family and broadens his life through substitution of outside interests and people. This is a difficult process for any child. In the best-adjusted child there is a certain amount of confusion and rebellion against the restrictions and ties of his own family. For this reason many parents send their children away to boarding school at this age to give them the opportunity to make the break as easily as possible.

In the adolescent who comes to the child-placement agency, this confusion or rebellion is apt to be more marked, since in many cases the reason for his coming is that there have been family difficulties and frictions. In dealing with these adolescents who are seriously confused about their parental relationships or who are in quite open rebellion against it—and particularly if this revolt has been increased by long-standing friction with the parents—we are requiring a great

deal of the child when we ask him to accept substitute parents, no matter how fine they may be. A school, in which he can develop the independence and adulthood he is striving for and at the same time have help in developing self-discipline and understanding of himself, is much more desirable.

A step beyond this group are those older children who have had considerable worldly experience and have pretty well broken their family ties. They have already learned to gain their life satisfactions in a larger field than the family. Many of these children are emotionally well adjusted, yet may still be in need of support and guidance. They have already reached one of the goals toward which all child training aims—the emancipation from the state of dependence on close family relationships. To ask children of this type to enter a foster home and take on a parent-child relationship with foster parents is to ask them to give up what they have accomplished and regress in their development.

Occasionally foster parents can take a child of this type into their home and allow him to preserve his more adult standards, but such foster parents are rare. These children can, however, accept a group in which they can still retain their individual, emotionally independent lives, and at the same time accept the more impersonal rules and guidance in the school situation. If they are intelligent and interested in academic education, they may do well in the straight preparatory school. If they are not interested in or capable of this type of training, they often profit from the trade school or camps of the N.Y.A. resident-center type. Perhaps this points to a need for camps of this kind, quite aside from the question of relief or unemployment.

It is always a temptation to feel that the child who does not make a good foster-home adjustment needs a group placement. This is obviously not true, but the harassed worker who sees the child break down in foster home after foster home finds it easy to rationalize that all will be well if the child is placed in a school or an institution. At least the child will be taken care of for a while.

Probably the child who gives the worker the most serious and long-continued problem is the neurotic child with a repetitive behavior pattern. We all know such children. They are apt to make a remarkably quick and satisfactory

adjustment to each new foster home. This is just the home they have always dreamed about. The foster parents are wonderful people and at last their troubles are over. They refuse to see any possibility of troubles or failure. Then, in a matter of a few weeks or months, the worker begins to hear faint, but familiar, mutterings of discontent, and the child again lives through the same general pattern of behavior that he has shown in his own home and in previous foster homes. The child himself cannot tell why he does it. Perhaps he still insists that everything is fine in the foster home, but this was some inner urge that he could not resist.

Usually, perhaps always, these neurotic patterns are those that have been developed as the result of his relationships with members of his own family during his early childhood, and are repeated in each new family situation that attempts to substitute itself for his own family group. These children are often the ones who have ambivalent feelings toward one or both of their own parents. Emotionally they cannot give up their own families, yet must continue their antagonisms toward them. With the antagonism there is considerable guilt feeling. When the foster family begins to show affection toward a child of this sort and he himself feels a response to the foster parents' approaches, it is too great a threat to him. It brings back all his earlier feelings toward his own family, and with these feelings the old pattern of reaction. The result is usually a bizarre type of behavior quite out of proportion to any evident cause. The child begins to steal, to run away, becomes hypochondriacal, withdrawn, or may show even more abnormal behavior.

It is very easy to reason that to remove these children from the family constellation to a group is the answer. It would seem that if they were not in a situation in which a substitute family called up the response, the pattern would disappear. Experience, however, has proven otherwise. Where these neurotic patterns are well established, the drive is so strong within the child that he must find expression for it regardless of the environment. He cannot leave the family behind just because he is physically separated from it. For these children the school does have much to offer, however. If the staff is a good one, it can give professional understanding. We cannot expect foster parents, unless

they are very rare ones, to understand this bizarre behavior when there is so little evident basis for it, but we should be justified in expecting a professional staff to see beyond the surface causes and not to be threatened by the behavior.

This understanding should be followed by what we may call "professional patience." The foster parents are emotionally concerned with the child. They have taken him into their home because of some need of their own. Therefore, we must expect them to have emotional reactions to the child's behavior. They become overattached and protective, or they become threatened by the child's behavior and reject him. The agency worker is frequently able to help the foster parents to understand the child's behavior and their own reaction to it, but this is not always possible, particularly where the misbehavior is severe and long continued. The professional staff sees the causes and remains relatively objective. In addition, there are many people in the institution to share the problem and each can carry a part of it and have periods of escape from the child and his difficult reactions. In the foster home, the substitute parents must bear the brunt of it for twenty-four hours a day.

For the child in the group, there is no family setting to serve as a stimulus for his drive. Therefore, the drive may be somewhat lessened, but it is not removed. Because of that one fact, group placement alone is not enough. If we know any answer for this small, but very important group, it is a good school placement plus good psychiatric treatment. To place these children in a group without psychotherapy is futile. To overcome his drives, the child must be helped to gain insight into them and thus learn to control them.

It is often very difficult, when a child is referred, to tell whether he belongs to this group. It calls for careful psychiatric diagnosis, and even this must often be tentative. It is obvious that at present clinic studies of all children referred to the child-placement agency are impossible and perhaps unwise. The social worker can pick out many cases that are obviously social problems and that can be handled on that basis. But when a child's behavior is not explainable on the basis of the reality situation in which he lives, we should be very careful about entering into placement without psychiatric help.

Many agencies, however, are located in communities in which such advice is not available. Where this is true, much can be done by the well-trained social worker. These questionable cases call for more careful study of the child's background and previous reactions, and careful thought on the part of the worker, before placement is attempted. The child's reactions in a temporary foster home also can give considerable insight before permanent plans are made. These children are definitely severe emotional problems, and so the psychiatrist should be called in if possible. This will help us to recognize some of these neurotic children at the beginning of placement, but even with this study it is probable that some of them will have to fail in one or more foster homes before we are able to recognize the pattern that their behavior follows.

Very close to the child with the neurotic behavior pattern is the child who is in reality seriously rejected by his own family and is unable to admit and accept this rejection. For many of these children, foster-home adjustment may be very difficult. This is particularly true if the foster parents' own children are in the home. Then the foster child is constantly reminded that there are children who are really wanted and loved by their parents, and who are secure in their own homes. This sets up an intolerable situation for the child whose one compelling desire is this same type of relationship with his own family.

Even if there are no other children in the foster home, it may be very difficult for this type of child. He is afraid to trust too close a relationship with other people, since his parents, the important people, have failed him. If he responds to the affection offered him by these foster parents, they, too, may fail him. In addition, he is being disloyal to his own parents by loving these substitute parents and is admitting to himself that he cannot expect love from his own parents and so must take it from outsiders. He cannot do this, so he rebels when he begins to feel the affection of the foster family.

In the school placement, none of the children are with their own parents. It is a recognized situation in the group, so it is easier for the child to accept the separation. The very fact that he is in a group all of whom are away from their

parents, and to some extent facing this same situation, gives a degree of security.

Again, however, group placement alone is not enough. These children must also have help in facing the reality of their situation and their relationship with their parents. These children are particularly subtle and confusing. They may appear perfectly happy in the protective environment of the group. There, without any need of facing reality, it is easy for them to fantasy and to convince themselves that their parents really want them and that there is some perfectly normal reason for the separation.

It is amazing to watch children in an institution who come in seriously disturbed about their family relationships. They may even tell lurid stories of the abuse they received from their parents and be frankly relieved to be away from the situation. Within a few weeks, many of them are thoroughly and sincerely convinced that everything at home is changed now and that much of the original trouble was directly the result of their own behavior. They paint beautiful pictures of the ideal home life and parent-child relationships and insist that these are a portrayal of their own homes. When this occurs, they are simply delaying the day when the truth must be faced and making it more difficult to accept. It is highly important, therefore, that there be members of the staff who are sensitive to this response and capable of helping the child. This need not be a psychiatrist, but must be some one who has a deep understanding of the emotional life of children.

The social worker who has been with the child during the break from home can be a very valuable person in helping the child face this situation. The worker knows the home and can often assist the child in accepting the reality better than the school worker, whom the child never knew in the home situation.

Sometimes our group placement may be based not entirely on the child's need, but also on consideration of the parents' need. In a private child-placement agency on which there are no legal controls, the parents are highly important figures whom we cannot leave out of the picture. They can often ruin all our fine plans for the child unless they are working in coöperation with us. This is probably also true no matter

what our legal status with regard to the child, but it is a more obvious situation in the private agency. Even though we may retain physical custody of the child in placement, his parents continue to influence his thinking, since they are still the most important people to him. Some parents have great pride. If they live in a closely knit neighborhood or have close ties with other family members, it may be very difficult for them to admit that their child is living in some one else's home. It puts the parents in a bad position since it implies that there is something wrong with their own home. These same people may be able to feel pride in reporting that their child is "away at school."

A more difficult situation for the parents is that in which they have strong guilt feelings about their child's placement. For these people there is a real threat in the placement of the child in a foster home in which substitute parents can help as they, the child's own parents, could not. Again, these people are not so threatened by a school placement.

When a child comes to us whose home and family relationships are pretty well broken down, and whose confusion and conflict over this situation is not so severe as to be considered neurotic, foster-home care certainly has much to offer and deserves our first consideration.

Even the best school or institution offers an abnormal situation for the child. It lacks the family pattern and the close ties with adults that the foster home offers. There must be many more restrictions in the group and less opportunity for the child to learn through experiments and to follow his own individual tendencies. One of the most valuable contributions that the foster home can offer, and that it is extremely difficult, if not impossible, for the school to give, is the experience of growing up in a normal community, with its varied contacts and experiences. Through these experiences the child prepares himself for adulthood in the environment in which he will live as a man. Two of the chief dangers that we must watch for in the school or institution are the regimentation of the child if he remains too long, and the fact that he may make an excellent surface adjustment within the protective environment of the school without there being any change in his real adjustment to life as he must live it when he leaves. On the other hand,

the right school can help us with many children who cannot accept foster homes because of either temporary or long-continued emotional difficulties centering about family life. They can also give more intensive and experienced supervision to the children who need it.

It is sometimes stated that the present shortage of foster homes is forcing us to use institutions, as if this were a regrettable move. Actually I believe that even before the shortage occurred, we were moving in this direction. The shortage of foster homes may make us give more serious consideration to institutional placement. If so, it is the only good thing to come from the situation. It is important that we use group placement on an intelligent basis because of its own values rather than as a substitute for foster-home care.

It is equally important that the institutions recognize their place in this field and make every effort to improve themselves to the point where they will have the maximum of services and skills to offer to the children who need them so badly. They should become aware of what services they have to offer and what the foster-home program has to give. It is seldom that we hear of a school's referring a child to a placement agency because the school feels that it cannot meet the particular needs of this child, while a foster home could. Have we not a right to expect this as well as to expect foster-home workers to recognize that some of their children need what the institution can offer?

The placement of children is an extremely complex and difficult job. It seems evident that both foster homes and schools are valuable tools, if properly used. We must not overlook either one if we are to do the best possible work. The decision as to which to use for any particular child must be approached on a case-work basis and determined by the peculiar needs of the individual child. The agency that uses both tools with discrimination can obviously do a better job than the one that is dedicated either to the idea of foster-home care or to the philosophy of institutional training and that refuses to recognize any other approach.

PSYCHOTHERAPY AND PUBLIC EDUCATION

O. SPURGEON ENGLISH, M.D.

Temple University Medical School, Philadelphia

PSYCHIATRY has been receiving an increasing amount of publicity in the past few years, and with good results, but we feel that even more public enlightenment would be beneficial. We shall try to give some of the reasons why we feel this to be desirable and some suggestions as to the lines along which we feel that this education should proceed.

First, however, let us enumerate some of the ways in which psychiatry has already come to public notice:

1. Through public knowledge of Selective Service screening procedures and consequent recognition of the fact that nervously vulnerable people are a liability rather than an asset—hence that it is better for all concerned to leave them out of service.

2. Through knowledge that a very high rate of casualties are due to emotional causes and that psychiatrists are important in the army medical program.

3. Through articles dealing with the emotionally disabled soldier and advice to relatives about him and what to do for him.

4. Through attention to the problem of the 4-F rejectee whose rejection has been due to emotional illness.

5. Through books, articles, and newspaper-column references to the relationship between emotions and body symptoms.

6. Through lectures to the public on the subject of emotional illness.

7. Through books on psychiatry for the layman.

8. Through more frequent allusions to the psychiatrist on the screen and the stage, notably in *Lady in the Dark*.

9. Through articles alluding to the psychoanalysis of prominent people.

All of these sources of information, and doubtless others that could be cited, have contributed to make the public aware of psychiatry and its many applications. They have helped to make the public less afraid of the stigma that has heretofore existed in regard to emotional illness or to being the recipient of psychiatric treatment. Probably partly as a result of this publicity—though also because of the fact that many psychiatrists are in the army—every practicing psychiatrist in the country is overburdened with work. All the same there should be, we believe, more publicity, in order to make the time spent between patient and psychiatrist easier and more effective.

First, the average patient goes to a psychiatrist quite uninformed as to what a psychiatrist does. Often he goes with doubt, scepticism, and misgivings. He may have been feeling socially, economically, physically inadequate for months or years, but going to a psychiatrist implies a weakness in him—a weakness that he does not associate with any other branch of medicine he may have to utilize. Consequently he may be defensive. He thinks, consciously or unconsciously, "I don't want to expose my mind to that doctor." "I dare him to tell me my emotions are weak or my ideas are wrong." "I don't like the implication that I need advice—that any other human being sets himself up to know more of what's good for me than I myself."

His resistance may increase when he arrives and meets a man under forty, without gray hair and beard, or a woman without at least gray hair. In other words, the patient feels that if he does deign to be guided by another human being, that being should have the wisdom of many years of living, presenting the popular visual image of a combined Moses, Freud, and Santa Claus.

The psychiatrist usually proceeds by taking a fairly detailed life history, including data on illness, and making a physical and neurological examination. Then he comes, as he inevitably must, to the matter of psychotherapy—therapy by way of the mind. Here the psychiatrist must begin to interpret, to correlate the facts of the history with the disability. Here we often find the patient sceptical, confused, incredulous, indifferent, or annoyed. One cannot do psychotherapy of any lasting value without calling attention to feel-

ings, attitudes, and longings that pertain to childhood rather than to maturity. One must refer sooner or later to love, hate, or at least their milder cousins, liking and disliking. Here we find how unaware people are of the fact that they hate any one, that they even dislike any one, that they could harbor the toxic effects of envy or jealousy.

As psychiatrists we must help our patients with some correction of selfishness, narrowmindedness, intolerance, ungenerosity, laziness, sensitivity, and suspicion, in order that they may become able to relate to those around them in such a way that they can draw the curative effects from friendship and social intercourse and creative activity. But in such an undertaking we have a thankless task. To accomplish it, we must allow time for the patient to come to accept these things as possibly being within himself; in fact, we have to proceed cautiously, assuring him by word and attitude that we are friendly and therapeutic rather than critical ogres merely out to take away what little self-esteem he has.

Furthermore, the psychiatrist, since he does know something of the thought processes of the mentally sick person, has to act as an intermediary between the unconscious mind and the prevalent accepted values of society. When he tries to get the average troubled person to see his true feelings, ideas, and emotions, he, the psychiatrist, is often regarded as fantastic in his theories and perhaps as the "crazy" one himself. The psychiatrist is often in the position of knowing too little of the truths of mental sickness to get in rapport with the psychotic, but of knowing too much of them to gain the most desirable rapport with the neurotic. The public should know, among other things, that the so-called insane man has much knowledge that is worth having.

Perhaps we can save time and get better results if we try, through public education on a large scale, to teach the potential psychiatric patient (which means any person anywhere) a few facts concerning human beings, such as the following:

1. Every one can be selfish, hateful, thoughtless, lazy, sensitive, lacking in courage, ungenerous, unfriendly, unsociable, unimaginative, illogical to some degree. Those with emotional illness have either more than the average of these

attitudes or have their emotional attitudes unsatisfactorily put together.

2. They are not to blame for the origin of the difficulty, as most of it arose before they could do anything about it. It merely becomes their fault henceforth if they do nothing about it.

3. Even though this implies discussion of the foibles of their parents, this does not result in producing a breach in friendly family relations, but merely a better understanding and tolerance all around eventually.

4. The psychiatrist may be young, middle-aged, or old, male or female, but he has specialized in helping people understand how emotional problems produce trouble. He does not judge—he educates and tries to help people become creative.

5. All people can benefit by learning new techniques of thinking, feeling, and living. Each person should go to learn these new techniques without taking with him the feeling that he must defend himself and prove what a wonderful person he is. The psychiatrist knows that no human being is always completely adequate. He can see what the person has accomplished as well as what he has not.

6. If your case needs a psychiatrist, go prepared to find out what is wrong with your mechanism for generating love, courage, good will, adaptability, energy for work, and decisiveness.

7. You will save your own and the psychiatrist's time if you accept these things and go willing to learn about yourself. The work of self-improvement can be interesting.

These points and others could be presented in articles, in personality sketches, in short stories, in radio dramas, in movies, and in plays, even in posters.

It seems that such publicity measures are not only justified, but imperative when we consider the large number of emotional casualties, the rejectees for emotional reasons, the neuroses in industry, the rising divorce and separation rate, not to mention psychosomatic illness.

Medicine has done more and more in the way of public education. Psychiatry of all branches has the greatest obligation in this regard, since, for instance, no person can set his own broken leg nor can his relatives do it satisfactorily, but in matters of human behavior every one works upon every

one else. Psychotherapy is everywhere, in the relationship of mother to child, of husband to wife, of employer to employee, and of teacher to pupil. Let us help them all, and at the same time help ourselves in the difficult cases that come to the psychiatrist, by reducing the time and effort necessary to break down resistance in psychiatric work. We may not change the situation much this year or next, but if we begin now, very appreciable results may appear ten years hence.

A SEMINAR IN PSYCHIATRY FOR THEOLOGICAL STUDENTS

ROBERT A. CLARK, M.D.
Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania
ALBERT H. BALDINGER, D.D.
Pittsburgh-Xenia Theological Seminary, Pittsburgh, Pennsylvania

WHEN the Western State Psychiatric Institute and Clinic was opened in November, 1942, one of its principal objectives was to establish useful and friendly relationships with other institutions in the surrounding community. It is well recognized that knowledge of psychiatry and of mental hygiene needs to be diffused outside the walls of mental hospitals. In this way much of the stigma attached to mental disease may be removed, and the sufferers may receive better understanding and earlier and better directed treatment.

With this in mind, the facilities of the hospital were offered to various types of educational institution in and around Pittsburgh. One of the first to respond was the Pittsburgh-Xenia Theological Seminary. With the approval and encouragement of Dr. Grosvenor B. Pearson, director of the institute, a seminar for fourth-year students at that seminary was planned, to be conducted by Dr. Clark, clinical director of the psychiatric institute, under the supervision of Dr. Baldinger, head of the department of practical theology at the seminary.

The psychology of religion has long held an important place in the curriculum of theological education. We know of no standardized theological school that does not offer one or more courses in this field. It is now generally acknowledged that religion and psychology have too much in common to allow either to ignore the other.

Not until very recent years, however, has theological education given anything like adequate attention to the therapeutic value of religion from the point of view of the working pastor. It is obvious that any aspect of religion that

receives scant attention in the training of the ministry will sink to a place of minor importance in the life and practice of the church. This is precisely what has happened to the healing function of religion. Its neglect by established churches has thrown the field wide open to diverse healing cults, many utterly subversive both of science and of religion. We now have scores of fanatical sects for whom health and healing are the be-all and the end-all of religion, as well as many pseudo-occult groups with similar aims.[1] The sobering fact is that the cults seem to be growing more rapidly in membership than any of the evangelical churches.

These current trends, together with the progress of modern psychology and psychiatry, are forcing theological education to recognize the validity of the healing function of religion and to evaluate afresh its available resources. In recent years the Department of Practical Theology in the Pittsburgh-Xenia Theological Seminary has tried to lift this aspect of pastoral work to its proper place in the student's consciousness and to make him more aware of its importance. In view of the seminary's limitations, both in professional staff and in clinical opportunity, it was considered a stroke of good fortune when the Western State Psychiatric Institute offered to supplement the classroom work by placing its teaching service at the disposal of the seminary.

The seminar in psychiatry and religion has now been given three times—in the spring and fall of 1944, and in the summer of 1945. Each time six weekly classes have been held, of two hours each—12 hours in all. Altogether, approximately 45 students have attended. The work is extracurricular and attendance is optional. That the students are not unaware of the constructive contribution that modern psychiatry is making to their work as ministers, and that they fully appreciate the practical value of these seminars, is evidenced by the fact that, with rare exceptions, every student given the privilege has promptly enrolled and has never been absent unless unavoidably.

The subject matter of the seminar has been arranged so as to introduce the student first to the mental hospital itself, and then to carry him out into the community by way of

[1] See "Theosophical Occultism and Mental Hygiene," by Robert A. Clark. *Psychiatry*, Vol. 7, pp. 237–43, August, 1944.

the mental-hygiene clinic and the general hospital, finally bringing him to the management of those who might come to consult him in his own study. An outline of a typical seminar follows:

> I. The minister and the mental hospital:
>
> The humane care and treatment of the mentally ill—history and modern practice. The place of the minister in relation to the mental hospital—visiting the mentally sick, chaplain to the mental hospital, advising relatives. Tour of the hospital.
>
> II. Religious trends in the mentally ill:
>
> The mental-hygiene function of religion. Depression and the sense of sin; religious ecstasy in hysteria and schizophrenia; prophet and Messiah in paranoia. Mental symptoms as magnifications of normal behavior and ideas.
>
> III. Special problems in the community:
>
> Alcoholism; its understanding and treatment. Delinquency. The psychoneurotic. When to call the psychiatrist. Group psychotherapy. The Research Council on Problems of Alcohol.
>
> IV. The religious cults and mental instability; their relation to human needs.
>
> Consideration of Christian Science, faith healing, Psychiana, Rosicrucianism, and Theosophy. The responsibility of the established denominations.
>
> V. The minister and the general hospital:
>
> Psychosomatic medicine. Advice for the frightened, the chronically ill, and the dying.
>
> VI. Adjustment problems:
>
> Critical periods: adolescence, marriage, senescence. Counseling—training by reading, by taking courses, and by living in mental hospitals. The ministry of listening. The minister's handicaps and advantages. Child guidance and psychiatric social work. Rehabilitation of returned service men.

Each class is begun by a lecture from the instructor, outlining the subject for the day. The students are encouraged to interrupt with questions and comments, and frequently do so. At every opportunity clinical observation and material are introduced to avoid didacticism. On the first day, for example, the students are taken on a tour of the hospital and shown typical wards, the occupational-therapy and hydrotherapy departments, the laboratories, the animal quarters, and the mental-hygiene clinic. On other days a number of patients are demonstrated, to illustrate clinical syndromes, with especial reference to symptoms involving religious matters, and to give a practical introduction to interviewing. In the fall of 1944, a representative of the Pittsburgh group of Alcoholics Anonymous told the students about his own history and about his organization. Suitable books are

frequently recommended. A list of some of these is as follows:

Anton Boisen: *The Exploration of the Inner World.*
Richard Cabot and Russell Dicks: *The Art of Ministering to the Sick.*
Albert Deutsch: *The Mentally Ill in America.*
Sigmund Freud: *The Future of an Illusion.*
Johan Jacobi: *The Psychology of Jung.*
C. G. Jung: *The Integration of the Personality.*
Fritz Kunkel: *In Search of Maturity.*
G. Canby Robinson: *The Patient as a Person.*
Carl Rogers: *Counseling and Psychotherapy.*
Elizabeth Stern: *Mental Illness: A Guide for the Family.*
Francis Tiffany: *Life of Dorothea Lynde Dix* (1890).

Several other books were reviewed by students as part of the last three courses—a cue taken from the course in advanced psychopathology formerly given at Harvard University, by Dr. C. Macfie Campbell. These included: *Religion and Health,* by Seward Hiltner; *On Being a Real Person,* by Harry Emerson Fosdick; *The Locomotive God,* by William Ellery Leonard; and biographies of Mrs. Eddy and of Swedenborg, by Dakin and Trowbridge, respectively. When the cults were to be taken up, an exhibit of their literature was prepared, including material obtained from the Jehovah's Witnesses, Psychiana, the Ancient Mystical Order of the Rosy Cross, the "I Am" Society, the Order of the Portal, and the Institute of Mentalphysics.

It has been hoped that the seminars have given the students an opportunity to learn, both by hearing and by observation, something of the art and technique of dealing with the mentally sick. Not the least profit, as some have gladly acknowledged, is the insight into and the better understanding of his own personality by the student himself. The major purpose, however, has been to give him sufficient knowledge to enable him to render, at the very least, first aid to mental casualties by a proper spiritual approach in pastoral counseling, and at the same time to safeguard him against the temptation to become an amateur psychiatrist.

Now that, with the ending of the war, more time is available, it is hoped that opportunities for more direct contact with the patients, similar to those offered by clinical clerking among medical students, will be made possible for the more interested students. Already two of the students from the last seminar have taken charge of the Protestant services for the hospital patients, and are doing an excellent job.

PRESENTATION OF THE LASKER AWARD IN MENTAL HYGIENE *

PRESENTATION ADDRESS

GENERAL OMAR N. BRADLEY

Administrator of Veterans Affairs, Veterans Administration, Washington, D. C.

I AM especially pleased to have been asked by The National Committee for Mental Hygiene to present the Lasker Award in Mental Hygiene to two distinguished leaders in the armies of our Allies. This is remindful of the teamwork that we shared, and I am happy to find that teamwork extended to the aftermath of the war. It is my hope that the work of these physicians may continue in peace the bond that made us great in war.

The Board of Directors of The National Committee for Mental Hygiene, having reviewed the recommendation of the Jury of Award and the records of achievement of its nominees, hereby designates Major General G. Brock Chisholm and Brigadier John Rawlings Rees to receive The Lasker Award in Mental Hygiene. This award, for the year 1945, is given for outstanding contributions to the advancement of mental health in the field of rehabilitation.

CITATION FOR BRIGADIER JOHN RAWLINGS REES

"As Consultant in Psychiatry to the Directorate of Psychiatry in the British Army, with the rank of brigadier, Brigadier Rees brought together a remarkable group of psychiatrists, brilliant, energetic, and resourceful in the development and application of new and old psychiatric concepts and practices. Under his aggressive and shrewd leadership and genial encouragement, this group functioned with extraordinary effectiveness in applying the best available scientific knowledge of human nature to aid the army in the use of its man power. Under heavy pressure they yet managed to maintain that continuous scrutiny and intelligent questioning of procedures and principles which made their experiences yield a maximal gain of increased wisdom and insight. In particular, Brigadier Rees and his associates developed the preventive aspect of army psychiatry. Eminently practical contributions thereto

* The Lasker Award of $1,000 for outstanding service in the field of mental hygiene is presented annually by the Albert and Mary Lasker Foundation, Inc.

were made through the systematic use of psychological and psychiatric skills in the selection of officers for qualities of leadership and through the application of psychiatric principles in the assignment of men to special duties. Our military leaders and the leaders of the armed forces of Canada gained much from the straightforward and energetic presentation of such principles by Brigadier Rees, on his visits here, and a wide civilian group was stimulated and enlightened by his Salmon lectures last November, published this year under the title *The Shaping of Psychiatry by War.*

"Rehabilitation of psychiatric casualties for reassignment in army duties or in civilian work was a continuing interest of Brigadier Rees and his associates. His basic determination to maintain a sound and progressively improving foundation for rehabilitation efforts is quite clearly shown in the directorate's files of reports of special studies, such as the employment of the blind in industry; the emotional, social, and economic situation of the war-disabled; the psychological problems of repatriated prisoners of war; and the development of techniques of popular education with respect to rehabilitation. In military psychiatric hospitals and in civil resettlement units, shrewd use was made of group discussion, social therapy, and democratic ward meetings, psychiatrically guided to help the soldier toward good social adjustment and the self-confident resumption of civilian living.

"So keen a man as Brigadier Rees must know that the title of his book, *The Shaping of Psychiatry by War,* is a misnomer. It is not war, but men who shape psychiatry, and John Rawlings Rees has been an outstanding leader among those who have been shaping psychiatry to serve in the war effort and to aid men and women to achieve healthy and satisfying lives in peace."

John C. Whitehorn

CITATION FOR MAJOR GENERAL G. BROCK CHISHOLM

"As a psychiatrist, soldier, philosopher, and administrator, Major General Chisholm has played a pivotal rôle in safeguarding the mental health of Canadian soldiers, and in laying sound foundations for the rehabilitation of ex-service men and women. During the early stages of the war, General Chisholm occupied the newly created post of Director of Personnel Selection for the Canadian army and was successful in developing an effective program for the psychiatric and psychological screening of recruits. In 1942, he was promoted to the post of Director General of Medical Services for the army, a position that is equivalent in status to that of surgeon general in the armies of other countries. As the chief medical officer of the Canadian army, the general brought about a needed reorganization of medical services and was responsible for the placing of emphasis on activities for the promotion of positive mental and physical health. His achievements were so great in this regard that, in 1944, when the end of the war was in sight, he was drafted by the Canadian Government to become the first Deputy Minister of National Health in the newly created Department of National Health and Welfare. This latter transfer was effected to take advantage of General Chisholm's leadership in the development of a comprehensive post-war national health program.

"One of the secrets of General Chisholm's success in the various posts he has held since 1939 has been the circumstance that he has

never personally sought positions of great responsibility, but, when once placed by army or governmental authorities in an official job, he has always preserved the right to conduct his work unhampered by political or irrelevant interference. It is interesting to note that the general's personal ambition was to be a combatant officer in the front line, as he was in World War I. Between 1914 and 1939 he was a keen student of military strategy. He was much more interested in military strategy and tactics than he was in military medicine. But the higher command of the Canadian army ignored his personal interests and ordered him to take a medical post. As a good soldier, he obeyed, but he took to his medical tasks the outlook of the fighting man in the field. Because of this orientation, he was eminently practical and was accepted by all ranks as a sound man, as a man whose advice must be heeded even if he recommended the incorporation of psychiatry and mental hygiene into the very fabric of military organization. Such advice he freely offered and he was always given the opportunity to put his ideas into effect. Fortunately, he had been well trained in psychiatry and his policies were invariably in line with good medicine and good military common sense.

"During the period of his attachment to the army, Major General Chisholm was chiefly responsible for the following achievements:

"1. The development of strong divisions of psychiatry, personnel selection (a corps of psychologists), and social science (a corps of social workers), with activities closely integrated with the work of medical and other officers to insure a total health approach in the Canadian army with mental hygiene as the central core of the program.

"2. The inauguration of the PULHEMS system[1] of examination of enlisted personnel to furnish profiles based upon mental and physical characteristics, to assist in suitable army placement. This system, in conjunction with job analyses of the 640 occupations in the army, facilitated the placing of square pegs into square holes.

"3. The focusing of the attention of all army medical officers upon the necessity for a psychosomatic approach in military medicine. Toward this end, General Chisholm arranged for the development of training courses of six months' duration for groups of medical officers—having them exposed to hospital work in psychosomatic medicine under psychiatric supervision.

"4. The development within the army of arrangements to foster good morale, with special emphasis upon officer selection and training, wherein competence to deal with the human factor was given prominence.

"In his new post as Deputy Minister of Health, General Chisholm is attempting to make available for returning soldiers, and for the civilian population, an even broader range of mental-health facilities than was enjoyed by the military forces. He has been active in securing Dominion Government funds for the improvement and extension throughout Canada of mental-hygiene clinics and counseling services; for the integration of psychosomatic medicine into general-hospital and public-health endeavor; for the support of mental-hygiene research and

[1] A system under which each enlisted man or woman is rated as to physique (P), upper limbs (U), lower limbs (L), hearing (H), eyesight (E), mentality (M), and stability (S).

training; and for the raising of standards of all psychiatric agencies in the country.

"His attitude toward returning men is that they should not become 'career veterans,' but that as soon as possible they should become citizens.

"The general is convinced that governmental agencies by themselves cannot do an effective mental-hygiene job. For this reason, he remains as President of the National Committee for Mental Hygiene of Canada and is mapping out partnership activities between this voluntary organization and the Department of National Health and Welfare.

"This citation would be incomplete without a reference to the fact that Major General Chisholm dares to think for himself and to share his thinking with his fellows. Since his mind is not shackled by considerations of orthodoxy, if prevailing attitudes offend his inner judgment, he is not reluctant to express convictions that may on occasions dismay those of his fellow citizens who are more conservative. In following this course, the general is rediscovering the truth that it requires as much courage to be a good soldier in peace as it does in war."

C. M. Hincks

ACCEPTANCE ADDRESS

BRIGADIER JOHN RAWLINGS REES

I FIND it hard to express at all adequately my deep appreciation and gratitude for the singular honor that you have done me in giving me this award. In fact, I regard it as a mark of your appreciation of what the psychiatrists in the British Army as a whole have done, rather than anything that I personally have been responsible for. I was very glad indeed that your selection committee did, in fact, recognize this in making their choice. Whatever we have been able to do in the war in psychiatry in the British Army has been very much the result of the work of a team. General Bradley has been known to us during this war as one of the outstanding examples of a man who can work in a team and in coöperation. I feel that the honor done to me is all the greater because General Bradley is here and taking a part in this meeting.

You paid me a further great compliment in bracketing my name with that of General Chisholm. He is a very old friend of mine, and I have always had a great respect for him as a psychiatrist and as a humanist, but not until this war, when I was privileged to see a good deal of him and the work that he was doing in Canada, and also in Europe, had I realized that he was also a first-class administrator,

nor had I realized how important that is. We must have men who are good technically and who at the same time are good administrators if we are going to make real advances in mental-health work for our peoples. We cannot do it by sitting at home, or just by meetings; we have to be where people are thinking and planning, and make our point of view obvious in the early stages of the arrangements for social legislation and indeed in almost every other department of governmental and political activity. We are all getting progressively more discontented with having to deal mainly with the salvage end of the problem, with those who are sick and sometimes almost hopelessly so, and our interest is very properly turning toward the ways and means of maintaining health and preventing ill health at its source.

In these days we, who are committed to this campaign for mental health, have a larger task than any one else. The war has challenged us, but the problems of peace are even more challenging, and we have an urgent responsibility to do something in practically every field of work or interest that exists to-day. At the present time we are all of us acutely aware of the new problems that have been raised by the liberation of atomic energy. Surely it emphasizes enormously the tasks that you and I have to face. We are concerned with helping people to a fuller and happier life, to greater maturity, and so to friendship and all those other positive qualities that are the antithesis of destruction. We must see that our growing knowledge and our point of view infiltrates to every level amongst the United Nations, so that, if possible, wiser ideas may be implemented for a better administration at governmental level. Our scientific lease-lend cannot stop and it must work in both directions, we in Great Britain and you in this continent making a major contribution from the English-speaking world.

This is one reason why I feel particularly gratified at being here to-day. I have many American friends and know them well enough to be able to laugh at them sometimes, and I have often poked fun at American hustle and efficiency. On this occasion my amusement is entirely superseded by amazement, because I have never come across such persistent efficiency as that displayed in the office of the National Com-

mittee, which—all in a flash, or so it seems—arranged ways and means and the magic carpet to bring me over here.

We in the services have been more fortunate than our colleagues. We have had opportunities to work with large masses of men and women and to carry out many types of experiment, some of which will certainly be of value for the mental health of the future when they can be translated into suitable forms for civilian life. It is probably a good thing that because of the pressure of work in war time in an army, we have had to put greater emphasis on group morale and group treatment than on work with individuals. Some great progress has been made in your army as in our own, and we shall be able to utilize this experience of the handling of groups for our work with the civilian population in peace time. Individuals matter, and the treatment of individuals is vital, but the knowledge that we get from that—and it can only be from that—can be applied to the handling of men and women in considerable numbers, so as to prevent the development of breakdown.

I have sometimes wondered before the war about the accounts that Dr. Frankwood Williams, one of your earlier directors, gave us about Russia, and the apparent diminution in emotional disabilities due to social change. Some of us had made tentative experiments with patients' clubs, and with groups, but on a very small scale. Experiments in the socialization of patients have been made here and there, notably in this country. The army has given us opportunities of seeing how, for example, suitable postings to jobs in which men can feel competent and proud of their contribution can affect their stability and their happiness. Dull men and neurotic men can give first-class service if they are properly placed.

We have learned a number of new things about the effective methods of treating people in groups, and through group occupations of building up that inner discipline which makes it possible for them to take their place either in the services or in civil life without further disturbance. We have learned to believe very much more in real democracy because we have seen that groups of men working on a democratic basis not only can choose their leaders, but can choose and effectively carry out their tasks; that even an authoritarian

structure like the army can benefit from the internal exhibition of democracy to a hitherto unbelieved extent.

In our special Civil Resettlement Units in England at the present time, through which returned prisoners of war are going, a great deal of this work is being carried out with very good effect. Group discussions, group occupations, group contacts with civil industry, and group therapy are all in progress. The same is true of some of our hospitals for neurotic men and women. There seems some possibility that our ministry of labor may take over, or at any rate utilize the methods of, these centers for civilian rehabilitation, and certainly much of the method is applicable in many spheres of work.

Time does not allow me to say more, and unfortunately time is not going to permit me to learn what I would like of the many advances and developments that you are making in this country. You have always set for us, and for the world in general, a very high standard of leadership in psychiatry, in sociology, and in general work for mental health. It is always thrilling to come to the United States, and I am extremely grateful that I am permitted to be here to-day. I am greatly touched by this award, and I am inspired by all the contacts with colleagues that I am having the opportunity to make. Thank you very much, or, as the children say at a party, "Thank you for having me."

ACCEPTANCE ADDRESS

MAJOR GENERAL G. BROCK CHISHOLM

MAY I convey to you and to the people who are responsible my most sincere thanks for this very great honor, an honor that you do to Canadian psychiatry through me, through the government departments in which I have had the pleasure and privilege of working in recent years?

I, too, would much rather share this award with Brigadier Rees than for him to have it all to himself. I have sat at his feet and garnered the crumbs of wisdom from him as far back as twenty years ago. I have no hope of catching up to him. Every time I go to England, I come back inspired with enthusiasm to do better than we are doing in Canada.

The same is true when I come down to the United States and see people using their heads to think with, which is a very refreshing thing to see.

One of the consolations of war is that people can no longer afford to putter about as they do in peace time. We must begin to think more than we have because we cannot go on making such fools of ourselves as we do in peace time. So in war time a certain number of people do become more realistic. Also, advances are more widely shared and are bound to be more acceptable to the people under the pressures of war. So for the last few years we have learned from each other. We have had the greatest possible coöperation from the United States every time we have found ourselves in a jam in Canada, and they have always kicked through and given us more than we have asked for. I would like to give especial praise to General Kirk and General Menninger in this connection, and also to Dr. Parran and his whole organization, who time and again have gone far out of their way to help the little country in the north, which needs help very badly very often.

I am just a little sensitive about this award because I feel I got it partly because I was director general of the services and happened to be a psychiatrist. Every time something happened in that field in Canada, I seemed to get credit for it. Actually, we have a consultant psychiatrist in that capacity in Canada who has been advising me for many years. Colonel Griffin, I am afraid, has been in difficulties in Canada because his boss happened to be a psychiatrist. He gets no credit for anything that is done because I always gather it in.

May I say again how very grateful I am in being here? It is an accolade recognized very widely as meaning something, and most sincerely I thank you for this privilege.

BOOK REVIEWS

EMPLOYEE COUNSELING. By Nathaniel Cantor. New York: McGraw-Hill Industrial Organization and Management Series, 1945. 167 p.

It is increasingly obvious that knowledge and appreciation of the personalities of individual workers are the base of successful industrial-worker relations, and that to understand a worker's adjustment in a job, one must be prepared to understand the emotional problems and perplexities he brings into the work situation. This viewpoint and something of the techniques of achieving such understanding are the essential material of this very helpful book by Nathaniel Cantor.

In Chapter I, the problem is well stated. In brief, the author says, "Industrial leaders . . . have been concerned with employee problems, the elements making for the problems, but they have ignored the employees as dynamic, living, feeling individuals who make choices. They have failed to realize that choices give rise to problems. To understand the problems one must first gain insight into choices. . . . The cure is not to be found in new organizational charts or changes in rules, but in the art of human relations and in the skill of applying it in communicating the wishes and attitudes of the different groups of the organization."

Chapter II sketches the historical development of counseling programs, beginning with the oft-quoted experiments of the Hawthorne Plant of the Western Electric Company. After reviewing some of the attempts to meet the employee-counseling problem, the author wisely points out the danger that such counseling programs will degenerate into routine clerical jobs, whereas they should be receiving renewed emphasis and orientation in a new direction. For the function of this newly-oriented individual, the author in Chapter III coins the term "employee consultant."

The functions of the employee consultant are outlined in considerable detail in the subsequent chapters, IV, V, VI, and VII. Chapter IV, on the basic psychological needs of workers, is an oversimplified, discursive treatment of motivation, in terms of a few drives—*i.e.*, dependence, independence, the will-guilt conflict, the need to find psychological balance, a sense of internal freedom, inner confidence, and a lack of disruptive fear. This chapter is weak because it gives relatively little understanding of the biographic

origin of such impulses, treating them more as phenomenological cross-sectional attributes of the personality. Chapter V outlines the consultant's rôle, point of view, and method of attack, and the development of the interview. Chapter VI develops this concept further, with excellent illustrative examples of interview situations, including failures as well as successes. Chapter VII, consisting largely of a detailed and lengthy case history, with the working out of a specific problem, develops further the basic principles of good interviewing.

The remainder of the book deals largely with the organizational arrangement of the consultant's function within the industrial structure, the requirements for the choice of good consultants, and specific details as to the setting of the consultant's activities and the keeping of records. Chapter IX, the final chapter, defines the counseling program in relation to the supervisor, the union, and management.

This book should have very real value in orientation to the general field. It is written somewhat above the level of the average foreman and shop steward, so that its major appeal should be to counseling groups and to top management. The author makes clear that most so-called employee counseling is a misnomer and that counseling, if it is to have any validity, must refrain from active intervention, guidance, or advice, and concern itself implicitly with the effort to help the employee resolve his own conflicts. The change has to take place primarily in the heart and mind of the employee, and the consultant should not concern himself with mere manipulation of environmental factors. This brings his function much closer to the functions of the psychiatrist and of the psychiatric social worker. With this orientation the reviewer heartily agrees.

This book should prove stimulating to all who are interested in industrial relations, and it is concrete enough to offer real guidance to those who are engaged in counseling or consultant activities.

LUTHER E. WOODWARD.

The National Committee for Mental Hygiene.

THE FOREMAN'S HANDBOOK. Edited by Carl Heyel. New York: McGraw-Hill Book Company, 1943. 410 p.

This book is intended as a reference text or handbook for consultation by foremen. The eighteen chapters are contributed by writers whose professional status can easily be checked by the reader in the brief listing and description of contributors that follows the table of contents. The style is dignified and the tone respectful.

Each chapter is a unit and can be read profitably for specific information without reference to what precedes or follows. As happens with any symposium, some writers have been more successful than others in presenting helpful information simply. The topics, too, differ in appeal. Mr. Heyel has done a careful job of editing.

While this handbook is a good reference source for foremen on the job, it is also wholesome reading for top management. The picture of what employees expect of the foreman is clear, although by no means complete. What his superiors expect and demand on occasion is also indicated, perhaps more by indirection. Executives frequently acknowledge the desperate plight of the overburdened foreman, but in critical situations they are likely to forget their previous observations. An occasional reference to the contents of this handbook would remind them of some of the reasons for the foreman's frequent feeling that he is "in the middle." In actual practice in many plants, he is still neither fish nor fowl, neither definitely management nor labor. In these days, when personal relationships are matters of far greater concern than in the past, the concept presented of the foreman as a leader, trainer, and interpreter is important.

While emphasis on getting out production is recognized in the handbook as still necessary, human engineering takes its place in importance, along with mechanical, electrical, and all the other types of engineering. The chapter on industrial fatigue especially highlights the effect of mental and emotional factors on productivity.

Perhaps the strongest chapter from the standpoint of human understanding is that written by Lydia Giberson, M.D., entitled, *Special Problems in Supervising Women.* The principles included in her discussion are applicable both to men and to women on the job. She calls attention to the fact that the special provisions for sanitation, health, and safety that have resulted from adding women to the labor forces have had a positive effect upon the improvement of working conditions for men. The emphasis on understanding, objectivity, clarity of outlook, dignity of procedure, and so on, are bound ultimately to affect the treatment of all employes, including foremen.

The easy planning that reduces a man to an automaton in the interest of efficiency is losing ground, but the procedures to be substituted are as yet not quite clear. The foreman of to-day needs better backing and understanding of his problems by management. He particularly needs help and coöperation in learning how to deal with the problems of personal relationships. This book provides a great many practical, wholesome aids to those ends. It presents neither propaganda nor sentimentalities.

As a whole, the handbook tends to emphasize in a very practical manner the dignity and worth of the worker, the foreman not excepted.

ESTHER H. DE WEERDT.

The Wisconsin Society for Mental Health.

GUIDANCE AND PERSONNEL SERVICES IN EDUCATION. By Anna Y. Reed. Ithaca, New York: Cornell University Press, 1944. 496 p.

The title of this volume inspired an enthusiastic hope in the mind of the reviewer; its reading brought real disappointment and a sharp concern for the future of "guidance" or counseling within the framework of the educational setting or elsewhere.

Miss Reed describes her own volume as the result of work and study over a period of thirty-five years, during which time she served first on the faculty of New York University, as Chairman of Personnel Administration in the School of Education, and later as resident lecturer at Cornell University.

The book is divided into five parts. Part I concerns itself with the history of guidance and personnel services prior to 1916. It omits any references to the visiting-teacher movement, although guidance services are defined by Miss Reed as covering those for which the visiting teacher—or the school social worker, as she is now called—has traditionally been responsible.

Part II deals with information on educational and occupational opportunities and community resources. It describes methods of collecting information in these areas and of classifying, indexing, and filing such informational material. Miss Reed disposes of recreational facilities in a few sentences and defines the purposes of privately (community-chest) supported social-welfare agencies in the following way: "Their main function is to supply clothing, glasses, braces, or other articles without which the attendance and education of the pupil would be blocked." She does advise school counselors to avail themselves of directories of social agencies in order to know what social services are available in their communities, but one wonders whether she herself has ever perused such a directory within the last five or ten years.

Part III concerns itself with information about the individual and describes the kind of data in this area that Miss Reed considers important for personal counseling: data on health, activities, teacher's marks, references and recommendations, and work experiences. Data secured from psychological testing, including personality tests, and methods of classifying, recording, and filing information about

the individual are suggested. The securing of the data seems to be conceived as something entirely apart from and antedating the initiating of a process through which the individual is engaged in making the most of his present and planning for his future.

Part IV deals with methods of using the informational data to which reference has been made above. It discusses group methods (without the faintest bow to the findings and experience of social group work), the counseling interview (with illustrative interviews which include such sentences as the following: "Many times it [the counseling interview] has a sales element, an element of motivation and persuasion, even though such element be carefully concealed," and, in comments on an illustrative interview: "Coöperation was in the offing! It was time to drop persuasion and shift back to counseling."), placement interviews, part-time school facilities, and methods of guidance, including guidance services for beginning wage earners, for experienced or mature individuals, and for older or retired persons, with brief acknowledgement of the services made available under the auspices of the Y.M.C.A., the Veterans Bureau, and the Red Cross Institute for Crippled and Disabled Men.

The final section of the volume deals with the organization, administration, and evaluation of guidance and personnel services.

In the final chapters on retrospect and prospect, Miss Reed gives evidence of warm concern with the problems of youth in America and genuine appreciation of the necessity of individualized service to help persons of all ages in the solution of certain problems in social living. Indeed, she italicizes the statements, "Personnel services must be ready to tune in on the international aspects of post-war problems," and, "Personnel services must be 'on tap' to assist in solving the domestic aspect of post-war problems." She deplores throughout the book the lack of any systematic professional preparation for guidance and personnel counselors, writing at one time, "Were a Gallup Poll to be taken, there would doubtless be stiff competition between the indifference of educational administrators and the inadequate preparation of functionaires to rank as the Achilles' heel of the guidance movement"; and later, "At the present time the professional preparation of guidance personnel has become a full-fledged racket."

And yet—astounding fact—she nowhere gives any indication of awareness that the very process she sees as so essential for professional counselors has already been reliably developed in schools of social work. Indeed, she mourns, "The original opportunity for professional leadership was lost. Low salaried, social service trained women whose interest was great and who for the most part had performed the early remunerated counseling services, were left in

possession of the field. The inevitable happened. A woman-dominated movement, except in areas confined entirely to women, does not command the status, salaries or prestige that a man-dominated or shared movement does." She insists, "It is not training for clinical psychologists [that should be provided], but something more general."

Why have administrators and guidance workers in the field of public education and vocational-guidance leaders elsewhere been so averse to using the contribution that the discipline of social work is prepared to make within the school or other setting offering "guidance" services?

Miss Reed seems to me to have answered that question in the following way. First, there is a generally held idea that the purpose of social-work agencies is to serve only what Miss Reed refers to as "sub-standard" youth and adults. There is no appreciation of the fact that social-work agencies exist to serve any person who qualifies for a given service at a given time. Miss Reed assumes that "normal children" require guidance and "abnormal children" social-work service. No such arbitrary distinction can be made. All children—indeed all people, bright, dull, economically comfortable or uncomfortable, emotionally disturbed or emotionally stable, sick or well—can profit from the kind of skill the social worker has developed through professional education, a skill that gives her a unique ability to enable individuals to work on their problems in social living, including the problem of selecting a vocation.

In the second place, there is general public confusion of the *program* of social agencies with the *nature of the social-work skill* which can operate in any setting designed to help people use or play their part in society's institutions. Part of the reason for this may be that schools of social work have been slow to recognize and act on this clarity of thinking about the nature of their task of professional education for social work. But that clarity has now been achieved and is reflected in the schools' curricula.

It is true that the field of vocational guidance requires on the part of counselors in that subdivision of the field about which Miss Reed writes a knowledge of what various jobs and professions require in the way of attitudes, abilities, and education; and what the vocational opportunities are in a particular locality. Bureaus set up for vocational guidance need to include on their staffs persons who have that specialized information, but they need also to have on their staffs persons equipped with a skill for helping individuals make choices and act on choices they have made, a skill that has to do with enabling individuals in all their individuality to see and

use opportunities available in the community. That is uniquely a social-work skill.

Miss Reed's volume seems to purport to be in itself a curriculum in guidance. Its purpose is high, its dedication great. It appreciates certain knowledges and skills that guidance workers need. It is grossly inadequate in establishing the nature of the requirements in professional education that will insure the development of those knowledges and skills. It substitutes lists of "do's" and "don'ts" and "principles" and "things to keep in mind" and outlines, for the self-analyses of counselors for a well-conceived program of professional education.

RUTH SMALLEY.

School of Applied Social Sciences,
University of Pittsburgh.

REËDUCATION IN A NURSERY GROUP: A STUDY IN CLINICAL PSYCHOLOGY. By Ruth Wendell Washburn. (Monographs of the Society for Research in Child Development, Volume IX, No. 2.) Washington, D. C.: National Research Council, 1944. 175 p.

This is the report of a project for the reëducation of young children with minor behavior problems and for the educational reorientation of their parents. The children attended the specially planned nursery school at Dr. Gesell's Clinic of Child Development at Yale University. Their parents had interviews with the clinic's child psychologist and watched their children through one-way screens in the nursery school.

The nursery enrolled from four to seven children as a "regular" group who came daily. These "regulars" were chosen because they were stable children who demanded little of the teacher's time and were an asset to the group.

Besides these children, there was a fluctuating group of children who came because their parents wanted help with their educational problems. These children came on the average for fifteen days only. (The range was from one to 115 days.)

The one-way screens were found very useful. They created a psychological distance between mother and child, enabling the mother to see her child in a new light. Observations were more effective than verbal, ready-made advice had been. In this situation a mother could feel that she was solving her own problems, not that an expert was talking down to her. Having won "insight" into her problem by watching her own child among other children and under the guidance of an experienced adult, the mother was more likely to

change her behavior. In about 10 per cent of the cases, the father, too, came to the clinic.

During the seven years covered by this report (1929 to 1936) the nursery served 260 children (150 boys and 110 girls). As is usual in guidance clinics for young children, *feeding* problems were more common than any other complaint (124 out of 260).

The staff offered parents practical advice on education and training. Many parents needed mainly the reassurance that their children's behavior tendencies were normal. Parents with deep-seated disturbances were referred to a psychiatrist.

The nursery was well equipped and the teachers showed great skill in understanding and interpreting the children's behavior. Thus students of early childhood, especially nursery-school teachers, will find in this book many interesting observations on individual children as well as descriptions of effective techniques. The teachers know how to get a child's coöperation without "bossing" him.

The report is written with a rare perceptiveness as to children's needs, and thus not only gives a number of answers, but also indicates points at which future studies could and should start. There is, for instance, the remark that most of the children whose parents sought help were of more than average intelligence. The author concludes that the brighter child is more ingenious in seeking its own ends and thus more often defeats the adult. This statement implies a severe criticism of our present attitude toward the young child.

It is also pointed out that many parents who came to the clinic had created their own problems because they had followed too faithfully the advice offered by earlier books on habit training. A mother who acts with the inevitability of a mechanical device ruins her human relationship with the child.

The study contains an outline, "Points to Think About While Watching Your Child," which will be helpful to any nursery in which parents or students observe. A brief chapter advocates the pattern followed in this school—namely, a core of children attending daily plus a group of children who come on certain days of the week or month—for other nursery schools.

In the nursery at Yale, all services to both groups were free of charge. No mention is made of where the financial resources were obtained nor how great the outlay as a whole and per child served had been.

This type of child-guidance clinic for young children seems to have been highly successful. There is no doubt that similar projects are needed in many places. The reader wonders why this one was discontinued, and whether offshoots are anywhere in existence to give help

to the many parents whose family life suffers by the tensions and deprivations of war time.

LILI E. PELLER.

Child Education Foundation,
New York City.

BRINGING UP OURSELVES. By Helen Gibson Hogue. New York: Charles Scribner's Sons, 1943. 162 p.

This little book of twelve brief chapters is a highly concentrated, but at the same time a most readable presentation of the best present-day knowledge and thought regarding the fundamental needs of children if they are to become the well-balanced, free, and sturdy personalties that a democratic citizenry must have if it is to hold its own in the complicated post-war world that lies ahead. The soundest of principles can be defeated by unhealthy personalities—as recent history has so painfully proved.

The author has drawn from three sources: first, from the accumulated technical knowledge of the several streams of thought that flow into our mental-hygiene reservoirs; second, from her own wide and practical experience with the application of these techniques to the lives of the men, women, and especially the children who have come to her for help with their everyday problems; third, from the free use of excerpts from the great thinkers and seers who have given us those timeless and universal insights that help us to understand and vitalize the deeper meanings underlying life itself.

The title of the third chapter might well be taken as the theme for the book—*Back of It All Lies Feeling.* The individual's need for the establishment of dynamic relationships with other human beings begins with his first breath. If this need is not understood by parents, physicians, and nurses, they may not use to best advantage those first years of a child's life when his basic patterns are being formulated and set, for even the physical care of a child has much to do with his future relationships to the world he lives in.

Several chapters—*Patterns of Escape, Patterns of Aggression, The Cinderella of Personality*—discuss the pitfalls that lie in the path of development, and some of the origins and causes involved.

Four chapters offer suggestions for meeting the commonest obstructions, thwartings, and misunderstandings that prevent individuals from reaching their rightful emotional stature and becoming fully mature. The following chapter headings indicate their content: *Psychologically Prepared for Work, Psychologically Prepared*

for Marriage, Resolving Tensions Creatively, The Religious Need. A final chapter briefly, but inspiringly, formulates "Our Heritage."

A well-chosen bibliography of suggested reading is included, so that the book will make an excellent text for classes both in college and in parent-study groups. It is authentic in content and so clear in style and vitalizing in feeling that one would wish it to be in the hands of every mother, teacher, and physician.

JULIA MATHEWS.

Child Guidance Clinic of Los Angeles.

HOW SHALL I TELL MY CHILD? A PARENT'S GUIDE TO THE SEX EDUCATION OF CHILDREN. By Belle S. Mooney, M.D. With an Introduction by Valeria Hopkins Parker, M.D. New York: Cadillac Publishing Company, 1944. (Distributed by Essential Books, New York City.) 192 p.

How Shall I Tell My Child? expresses the current point of view that the major responsibility for sex education belongs to parents in the home, rather than to the school or church. The book is concerned more largely with fostering positive parental attitudes for doing this job than with unfolding to parents a clear picture of sex physiology itself. This is apparent in the distribution of space for material, as well as in the emphasis of the writing. There are five parts: *The History of Sex Education* (pp. 21–45); *Typical Questions Asked by Children* (pp. 45–74); *Questions That Parents Ask* (pp. 77–152); *The Age for Sex Education* (pp. 154–171); *A Concise Dictionary of Physiological Terms* (pp. 172–190).

Specific questions that children ask about birth and growth are taken care of in 29 pages. The remainder of the book is given over mostly to a discourse on the place of open, wholesome family treatment of sex curiosity and information, as opposed to the hypocritical taboos of our society. The informed parent of to-day, who has already decided to face the reality of helping his children to get sex education, does not need to be argued into this all over again and at such length. He will want more well-illustrated biological information; and he will want to know how to pay it out gradually over the years in proportion to the curiosity for detail that his children show as they grow up.

It is possible that Dr. Mooney believes this area of information is adequately covered by such incisive books as Strain's *New Patterns in Sex Teaching* and, at the adolescent level, by Levine and Seligmann's *The Wonder of Life.* For she makes only a sketchy attempt to depict the basic processes of reproduction.

The point is made that the "reason why parents do not know the

correct terms for the body and the body functions is merely that they have themselves retained the vocabulary of their own childhood, instead of growing up mentally to use the language of maturity," and that "father and mother may not know all the fine phraseology that exactly describes these marvelous functions—few are so gifted—but they can tell the simple facts that they do know honestly and unashamedly in the best words at their command." To know a glossary of terms, or to limp through a scant, faulty explanation, is not the same as understanding enough sex physiology to answer questions adequately. Most adults experience parenthood, yet few adults understand the dynamics of their experience. A parent can use the proper terminology only when he has a clear picture of what he is trying to explain. A book that is "a parent's guide to the sex education of children" should give this picture.

The chapter, *Questions That Parents Ask,* describes the anxieties and prejudices that adults experience in handling sex education. The author presents an extensive array of questions, treating each one with that degree of social common sense which makes the dictum of the expert more palatable to the layman. Both here and in the section, *The Age for Sex Education,* Dr. Mooney makes it clear that sex information, given increasingly over a period of years, has little constructive value in the life of a child unless the parents demonstrate self-respect, naturalness, and lack of prudery in their own family attitudes. This point is well taken.

On the other hand, the value of summary statements as to the degree of information that all children should have by the ages of three, five, and twelve years—without consideration of individual differences in curiosity, intelligence, or environment—is questionable. There is also ground for divergence of opinion on the subject of nakedness as the antidote to the shame attitude in family relationships. Self-consciousness as a natural corollary to growth is not mentioned.

While *How Shall I Tell My Child?* may lack completeness as a guide to parents, it shows a sound understanding of contemporary parent problems. Much of its material will, therefore, be helpful to educators and group workers who want information that will help them to deal with a variety of parental attitudes and responses.

EVELYN D. ADLERBLUM.

The Kindergarten Demonstration Project,
P. S. 33, Manhattan, New York City.

THE PROBLEM OF CHANGING FOOD HABITS. Report of the Committee on Food Habits of the National Research Council, 1941–1943. Washington, D. C.: The National Research Council, 1943. 177 p.

Late in 1940, the National Research Council, of Washington, established two committees—a Committee on Food and Nutrition, and a Committee on Food Habits. In appointing the second committee in addition to the first, the National Research Council "acted on the assumption that, while the first step toward achieving an adequate national nutritional level is the securing of scientific information on what constitutes proper diets, there remains the second step, requiring an equally scientific approach, of finding the most effective ways and means of adjusting habits to needs, of getting people to wish what they need."

The publication under review is the report of the Committee on Food Habits for the years 1941–43. It is a compilation of papers and reports on research undertakings by various groups. A brief account of some of the papers will give an idea of the purposes and methods of the committee.

In his report, entitled *The Forces Behind Food Habits and Methods of Change,* Kurt Lewin gives a good deal of emphasis to the various "channels" that affect people's food habits, the word "channel" being used to describe the various methods by which food is brought to the table. The material was collected from the residents of a Mid-Western industrial town, with a population of about 60,000, which has employed a nutritionist for a number of years The groups studied were the low-income, the middle-income, and the high-income group, the Czechs, and the Negroes. In all, 107 housewives were questioned.

The author goes on to describe his experiment to determine the comparative effectiveness of two methods of changing food habits. One of these methods is that of group decision—that is, the group decides for itself whether and to what degree it wishes to change its food habits. The second is the request method, the group being asked to make a change in a particular food habit instead of deciding upon the change itself. It was found that with the group-decision method the individuals seemed more eager to succeed and that, irrespective of their personal likes and dislikes, they were more willing to coöperate as a group. In still another study the effect of a nutritionist in a group-decision setting was compared with the effect on a group to whom she lectured. Again the group-decision method proved to be more successful.

The report entitled *Adjustment to Dietary Changes in Various Somatic Disorders,* by Hilde Bruche and Marjorie Janis, deals with the influence of psychological factors upon the adjustment to a prescribed diet. More than 200 obese children were studied at

the Pediatric Department of the Columbia-Presbyterian Medical Center in New York. In practically every case, it was found that the mother rather than the child was the great obstacle to carrying out dietary recommendations successfully.

Patients with other conditions that require dietary treatment were also studied. Belief that it would cure their disease stimulated these patients to carry out their prescribed régime. Among these latter patients, individuals representing three types of reaction were found: (1) those with an intellectual acceptance of the régime, who gave good, though not rigid, coöperation; (2) the neurotics, who were more coöperative because for them a cure represented a reward and failure to be cured a punishment; and (3) the uncoöperative group, for whom the whole pattern of living seemed to be disturbed by changes in eating habits. The authors correlated these findings with the food problems that face the nation to-day and reach the conclusion that people who are reasonably secure will accept food limitations in their eating habits and that intellectual acceptance will be the normal pattern. Neurotics, however, will need special guidance, as they will react with fear and panic to food shortages.

A study on the use of the "friendship pattern in nutrition," carried on in New York by Earl L. Koos, showed definitely that the use of friendship as a channel for the diffusion of knowledge in nutrition was not successful because it was too individual, without any definite intellectual guidance. The author suggests that the use of strong local organizations for the diffusion of information is far more effective. Here, again, we see the group medium brought into play.

A paper by Gladys Engel-Frisch discusses the food habits of war workers. She points out that the different shifts are affecting the life of the worker and his family. She mentions the inadequacies of feeding facilities in plants. It is a great satisfaction to note that since this report was written many plants have been taking steps to provide better facilities for feeding the worker, since they realize that better feeding affects the health, mental attitude, and efficiency of the worker.

Virginia Van Dyne Fleming contributes a paper entitled *The Federal Employee Turnover in Washington with Special Attention to Living Habits.* Reporting that meals are often eaten alone and are inadequate because they do not supply the body's need for both physical and mental health, she emphasizes the value of eating in groups with friends rather than alone.

Rhoda Metraux, in a paper on qualitative attitude analysis, shows how to take a popular poll to find out what are the mental attitudes

of people toward food. This does not of course, serve any educational purpose unless the figures secured stimulate further teaching of nutrition to various groups.

Natalie Joffee, Technical Assistant of the Committee on Food Habits, discusses methods of working with the food problems of the foreign-born group. She suggests that in such a study a volunteer collaborator of appropriate background, who has also had some training in the social sciences, serve both as co-author and informant. This background can be enhanced, the reviewer suggests, by visiting foreign stores and restaurants where foreign foods are sold and served. Experience has shown, also, that success is far more likely when the worker is identified with the people and understands their cultural background.

Miss Joffee also discusses the emergency rations that might be used in feeding liberated countries. Again she suggests the services of a trained person who has a knowledge and understanding of the cultural background of the people of these lands.

In another study Herbert Passin and John W. Bennet compare the changing cultural patterns of two groups—one of American and the other of German descent. It was found that the more closely the foreign-born lived to the American group, the greater the changes in their food habits. The rural group remained more self-sufficient and less influenced by the modern methods of trade than the urban group.

The latter part of the publication is devoted to summaries of committee conferences. These include abstracts of the researches carried on by colleges, government agencies, trade organizations, and institutions related to health.

It was felt at these conferences that food habits could be changed. One group was of the opinion that even with limited economic resources, food habits could be improved, by proper teaching. Another group, however, claimed that one-fourth of the people in the United States could not afford even the cheaper forms of an adequate diet. The standards of the Nutrition Research Committee are planned in optimal amounts and are practically unattainable for most of the lower third of the population.

The conferences were largely devoted to discussion of the food habits of children. The following factors involved in getting children to eat were stressed—(1) watchful neglect; (2) pleasing atmosphere; (3) social conversations; (4) small portions; (5) paired liked-disliked foods; (6) matter-of-fact attitude toward refusals; and (7) good adult example. It was estimated that the food aversions of family members associated with children's aversions were as high as 35 per cent. Habits formed in the first five years of the children's life are vital; therefore, prevention rather than reëdu-

cation was emphasized. That feeding is the infant's effort to satisfy his social and affectional needs as well as his hunger was also pointed out.

The various speakers also discussed methods of educating the public. Trade organizations showed how, through the distribution of educational material containing sound scientific information, they were able to help the communities throughout the nation. It was stressed that educational material must be attractive and colorful. It was also pointed out that magazines do not reach the lowest-income group; this group is reached rather by newspapers and the radio.

A member of the Boston Dispensary Food Clinic showed how, as a result of the experience of twenty-five years, the clinic serves the need of the out-patients for scientific food guidance as an aid to successful medical treatment. In the clinic the dietitian plans the dietary régime on the basis not only of laboratory and medical findings and recommendations, but also of her understanding of the patient and the economic, social, mental, and emotional factors in his life, gained from the medical record—physical and mental—and from the nutritional history, which she takes in conference with the patient.

It was also pointed out that teaching the patient is most essential to successful food treatment. To understand why he should adhere faithfully to his diet, the patient must know why certain foods are prescribed for him. So the dietitian helps him to understand that foods contain substances or constituents like those of which the body is composed; how these food constituents aid in upbuilding and maintaining health, growth, and vigor; and why the foods in his diet will serve his special needs for health. Other members of the patient's family may be brought into this teaching program, in order to obtain their understanding and coöperation.

The food clinic is constantly developing materials to help interpret these principles of nutrition. Simple exhibits that the patient can understand have proved to be most essential as a means of visual education. Thus the food clinic contributes to the improvement of the health of the community.

It will be seen from this brief account of the report that many individuals and organizations are devoting themselves to research, to secure information as to the food needs of the people of the nation and the best methods of adjusting habits to needs in terms of physical and emotional life.

RAE R. GOLDBERG.

Food Clinic, Beth Israel Hospital,
Boston, Massachusetts.

BALANCED PERSONALITY. By F. Alexander Magoun. New York: Harper and Brothers, 1943. 304 p.

The subtitle, *How to Solve the Conflict Between Desire and Conscience,* states the problem and purpose of this book. Thus the author sets himself the task of describing, and showing the relationships between, motivation (desire), conscience, and conflict, generally considered the three most basic processes in human behavior. Further, the subtitle promises a method for the solution of the problem of conflict, obviously the central problem in mental health. Clearly the task is a very difficult one.

Balanced Personality is written in nontechnical language and addressed to ordinary men and women. The thesis of the book is avowedly simple, and Professor Magoun takes pride in that simplicity. To quote from the preface:

> "The idea that the personality behaves like a teeter-board, with Desire and Conscience moving up and down in the plane of action and restraint, while Wisdom moves from side to side in the plane of decision, is a simple one. The explanation can be simple even if the total thing to be explained is not. All fundamental truths are simple, even the most important concepts of physics or chemistry or human behavior. . . . There are two kinds of simplicity in the world: the simplicity of ignorance, and at the other extreme the simplicity resulting from a knowledge which can discard everything except the essential."

Here, briefly stated, is the central idea of *Balanced Personality* and something of the author's attitude toward the presentation of the idea.

The book is composed of ten chapters. The first is a very stimulating, brief survey of the background of modern psychology, sketching the development from magic to science, and closing with a high, but balanced tribute to the contribution of Freud. The next chapter describes the three aspects of the personality, Desire, Conscience, and Wisdom, as a whole. "Where Wisdom succeeds in getting Desire and Conscience to work together in harmony, we say that a person has balance" (p. 18). "Wisdom is seeing reality with vision and a sense of proportion" (p. 19). The remaining chapters are given to a description and analysis of the three factors just mentioned. In Chapter VI—in my judgment, the most valuable chapter in the book—there is a very helpful presentation of the excellent work done in recent years on the relationship between frustration, emotion, and aggression.

Throughout the book, the author personifies the three principal factors involved in the balanced personality—Desire, Conscience, and Wisdom. In the drawing illustrating the general thesis of the book, Desire is shown as a trimly buxom girl, none too hesitant about showing her knees, challengingly seated on one end of a teeter-board;

Conscience is pictured as a tense, overclothed (even to high shoes), exacting young lady, determinedly seated on the other end; while Wisdom, a self-confident, manly, and intelligent man, stands on the board with one foot on each side of the fulcrum, a carpenter's horse rather insecurely foundationed. Wisdom tolerantly shifts weight in order to create balance between Desire and Conscience. Although doubtless the personification adds interest and clarity, particularly for the nontechnical reader, the more sophisticated reader may grow somewhat tired of its use.

The chief strength of the book lies in its extensive use of apt case material of a very varied sort, revealing the wide experience of the author, and in the rich, insightful common sense often expressed concisely and strikingly. Two or three quotations will illustrate the latter quality: "He [Freud] knew that the answers one gets are always in terms of the questions one asks" (p. 7). "Self-domination is not self-control. When discrimination is present, the personality soon comes to want to want what it ought to want" (p. 26). "You can destroy a habit easily only when the Desire that goes with it is slight" (p. 34). "The essence of real happiness is a personal integrity which never attempts to accept anything until almost the whole self believes it. Disagreement and sin and pain make things tighten. Agreement and truth and happiness make them relax. The first lead to slavery and inner bondage; the second constitute freedom and emotional balance" (p. 131).

There are two suggestive appendices: A. *Habits of an Educated Man,* and B. *Good Method in Human Relations.*

E. V. Pullias.

George Pepperdine College, Los Angeles, California.

First Course in Psychology. By Robert S. Woodworth and Mary R. Sheehan. New York: Henry Holt and Company, 1944. 445 p.

In preparing this textbook for beginners, the authors have succeeded to a notable degree in relating some of the facts of psychology to the interests and experiences of the immature student. Although the authors indicate in the preface that the book was intended to be used as a text for college freshmen and sophomores, both the style and the content seem better suited to the high-school level. References to the experimental literature are conspicuously lacking. The only persons associated with psychology named in the index are Bacon, Binet, and Freud.

Each of the twenty-seven chapters is intended to constitute a weekly unit of work. The subject matter is enlivened by many simple and

interesting experiments—utilizing drawings, photographs, and similar material—which are to be performed by the student as he reads. Further experiments of a more elaborate character, as well as questions for review, are suggested in the exercises at the end of each chapter.

The topics of the first two chapters—entitled, respectively, *Learning to Understand People* and *Dealing with the Environment*—were apparently chosen with reference to the popular concept of psychology as a device for fostering one's social and material well-being. The pedagogical rule of "beginning where the pupil is" is thereby satisfied.

The next six chapters deal with various practical aspects of learning and forgetting, and include a useful discussion on how to read. This section is followed by four chapters on perception and thought, seven chapters on motivation, interests, and emotions, and five chapters on individual differences in intelligence and personality. A chapter on heredity and environment stresses the interaction of the two factors and attempts to straighten out some of the popular misconceptions on the subject.

Suggestions for choosing a vocation are summarized under such popular captions as *Blind-alley Jobs, I Don't Want to be a Career Woman,* and the like, in the chapter headed *When I Finish School.* In the two final chapters, some of the fallacies of the Sunday-supplement type of "popular psychology" are exposed, together with a very brief account of known facts about such "mysteries of the mind" as hypnotism and extra-sensory perception (or E. S. P., as it is generally termed). To the reviewer at least, the desirability of this phrase is highly questionable, not only because of its metaphysical implication that the mind is something distinct from the body, but even more because of the implication that this something is "mysterious" and unknowable. The psychologist should be too well aware of the influence of slogans and catch phrases to use them carelessly.

A five-page bibliography of "Books on Careers" and a glossary complete the volume. Definitions in the glossary have been couched in exceedingly simple terms. While the process of simplification does not appear to have led to any gross misconceptions, many of the terms will require a more precise formulation at the college level.

FLORENCE L. GOODENOUGH.

University of Minnesota, Minneapolis.

PERSONALITY AND THE BEHAVIOR DISORDERS; A HANDBOOK BASED ON EXPERIMENTAL AND CLINICAL RESEARCH. Edited by J. McV. Hunt. 2 Vols. New York: The Ronald Press, 1944. 1242 p.

It is difficult to overpraise the contributions and organization of the thirty-five chapters that have been assembled in these two volumes under the editorial direction of J. McV. Hunt. Each chapter is by an authority, and is competently written and amply documented. At every point the literature is adequately reviewed and skillfully organized. Included here are the relevant contributions of the various life sciences, from physiology and brain lesions to culture and human ecology. The great wealth of recently developed theory, of experimental work, and of clinical research is generously displayed. The integration of this enormously varied material is an outstanding achievement.

In Part I, the initial chapter, by Donald W. MacKinnon, presents in very small compass an excellent survey of definitions and of theories concerning the organization of personality. Edward R. Guthrie summarizes his thesis that personality can be studied in terms of habit adjustment. O. H. Mowrer and Clyde Kluckhorn develop and elaborate with many original observations the dynamic theory of personality that has emerged from the interaction of the basically similar assumptions of psychoanalysis, of social anthropology, and of the psychology of learning.

Part II is concerned with the assessment of personality. It includes a discriminating chapter by Edward S. Jones on subjective evaluations; an adequate, but perfunctory chapter by J. B. Maller on tests; and a stimulating chapter by Robert W. White on projective and imaginative techniques.

Part III, devoted to studies of the dynamics of behavior, is introduced by a brief statement by Dr. Thomas M. French, pointing out the importance of psychoanalysis as a scientific method, suggesting the wealth of hypotheses for experimental research that its clinical material has provided, and indicating the types of problem on which the coöperation of clinical and experimental approaches may be most fruitful.

Dr. Leon J. Saul assembles the extensive evidence that many physical and physiological ailments—such as nervous vomiting, peptic ulcers, diarrhea, constipation, essential hypertension, asthma, headache, and enuresis nocturna—are often caused or aggravated by emotional tensions.

The efforts of psychologists to subject Freudian concepts and theories to experimental investigation are reviewed by Robert R. Sears. He makes the sound observation that merely testing psychoanalytic concepts is apt to be futile and that the most important

contributions have been and will be made by psychologists intent on the systematic development of habit, learning, and personality theory, using behavioral data.

Kurt Lewin, Tamara Dembo, Leon Festinger, and Pauline S. Sears summarize the scanty literature on the important problem of aspiration levels and erect what seems to this reviewer an overly elaborate theoretical structure to guide future research.

A brief statement of frustration theory by Saul Rosenzweig is followed by three outstandingly notable chapters summarizing experimental studies of neuroses, of behavior disorders, and of conflicts induced with laboratory animals. These chapters are, respectively, by H. S. Liddell, by Frank W. Finger, and by Neal E. Miller. The nice integration of theory, of hypothesis, and of experiment displayed by Miller's chapter is most promising for future research. This section concludes with an excellent outline of hypnotic phenomena by Arthur Jenness.

Part IV, concerned with the biological and organic determinants of personality, begins with a mediocre chapter on heredity by Dr. L. S. Penrose. William H. Sheldon reviews the literature on constitutional factors, including a brief summary of his own important and exciting contributions. Dr. Stanley Cobb illustrates the influence of brain lesions on personality and discusses some prevalent misconceptions with forthright vigor. The difficult field of physiological factors is ably surveyed by Nathan W. Shock.

The determining influences of infantile, of childhood, and of adolescent experience and of cultural and ecological factors provide the topics of Part V. Dr. Margaret A. Ribble presents a much needed plea, marred by minor exaggerations, for more psychological mothering during infancy. An exceptionally well-organized discussion is that by Lois Barclay Murphy on the contributions to personality during childhood of developing skills, of social experience, of individual growth patterns, and of family and neighborhood influences. Phyllis Blanchard summarizes a number of the major contributions to the understanding of adolescent personality, without, however, finding much integrating significance in these various contributions. The brief chapter on cultural determinants by Gregory Bateson is a model of comprehensiveness and lucidity. Robert E. L. Faris presents statistical evidence that the social disorganization found in the slum areas of large cities is important in producing delinquency, crime, vice, and mental disorders.

The various types of behavior disorder are the concern of Part VI. This section is introduced by an outline of difficulties in childhood by Dr. Leo Kanner. Dr. Lawson G. Lowrey discusses the mechanisms of personality formation that are most often found among, but are

not peculiar to, delinquents. It is not the social disorganization of a slum area that produces delinquency, but, in part, the way in which such disorganization is "transmuted in the subtle alchemy of personality integration."

Dr. A. Warren Stearns, after a wholly irrelevant introductory statement, contributes an interesting miscellany of 42 thumb-nail sketches of individuals unfit for military service. The chapter on the psychoneuroses by Dr. William Malamud provides an exceptionally clear and well-organized exposition. The much more difficult and controversial subject of functional psychoses is admirably treated by Dr. Norman Cameron in a long chapter which is notable for its full citation of the relevant literature. Dr. Paul William Preu examines the scrapbasket diagnosis of "psychopathic personality" and summarizes the more important theoretical formulations. Dr. William G. Lennox discusses recent significant research on epilepsy and migraine and outlines briefly their personality concomitants.

Part VII consists of two unrelated chapters: one by J. McV. Hunt and Charles N. Cofer on a wide variety of deficiencies associated with personality disorders, and the other by Donald B. Lindsley on electroencephalography. Lindsley's review of this new and highly promising procedure is the most complete and thoroughly documented account so far published.

The final section, Part VIII, consists of a chapter on psychiatric therapy by Dr. Kenneth E. Appel and a chapter on the prevention of personality disorders by Dr. George S. Stevenson. Beginning from quite different points of departure and presenting wholly different materials, these chapters, nevertheless, stress essentially the same basic fundamentals.

The two volumes provide a rich, varied, and abundant fare to satisfy the most exacting tastes of the many specialists interested in personality. Graduate students, teachers, research workers, and clinicians will be immeasurably indebted to the editor and the forty authors for their labors.

FRANK K. SHUTTLEWORTH.

The City College, College of the City of New York.

A FUNCTIONAL APPROACH TO FAMILY CASE WORK. Edited by Jessie Taft. Philadelphia: University of Pennsylvania Press, 1944. 208 p.

This volume of the Social Work Process Series consists of a collection of eight articles—or more accurately nine, since the discussion of one of them is a brief article in itself. Four of the articles have a

direct bearing on the problem of function in family case-work. These are Jessie Taft's *Introduction;* Elizabeth H. Dexter's *Problems of the Private Family Agency in War Time;* Rosa Wessel's *Some Problematic Aspects of Function in the Family Agency as Revealed in Two Cases;* and M. Robert Gromberg's *The Specific Nature of Family Case-Work.*

The article, *A Social Agency Appraises Its Work with Refugees,* by Sarah S. Marnel, and the discussion of it by Helen Wallerstein do not deal with functional problems *per se* so much as special aspects of work with refugees in a family agency. Francis T. Levinson's *The Use of Fee in the Case-Work Process in a Family Agency* stresses the difficulties encountered by client and worker in the use of a fee as well as the positive values it has for each participant. The article is not, however, concerned with function as such in a family agency.

The two remaining articles—Miss Marcus' *The Relation of Case-Work Help to Personality Change* and Virginia P. Robinson's *A Discussion of Two Case Records Illustrating Personality Change*—have validity for any social case-work agency. They are more directly associated with the function of the social case-worker than with the function of family case-work agencies.

In one sense it is not possible to review the book as a whole, though the thread of functional case-work unites all the articles. Readers will have particular interest in Dr. Taft's *Introduction* because she replies to some of the more frequent criticisms of the functional method. The nonfunctional case-worker will not agree with all her answers, but it is good to have the pros and cons on the table.

In discussing the specific function of the family agency, it is inevitable that the Home Service Division of the American Red Cross should be cited as in need of clarifying its function. It is worth noting that none of the authors who bring the Home Service Division into their discussions have stressed certain structural forces that aggravate the Red Cross problem: the quasi-public nature of the American Red Cross, and its responsibility to the military. Mrs. Wessel does, however, state very well another factor of great importance—the conflict between public opinion, which would force Home Service into truly becoming the great mother, and professional case-workers who, whether functional or not, must observe certain principles that interfere with such an enveloping and undiscriminating rôle.

It is quite clear that we have as yet no new answer to the question, "What is the function of the family agency?" Dr. Taft leads us to expect one in Mr. Gromberg's article, but his statement (p. 114) "that a family agency, as differentiated from any other, is intended to deal with the problems which primarily concern the *family as a*

whole'' is an anticlimax. Neither this concept nor his emphasis on helping members of a family group to fulfil their proper rôles presents anything different from what has been taught and practiced for years.

The statement that Mrs. Marnel and Miss Wallerstein both indicate the use of diagnostic thinking in the nonfunctional sense of the phrase will probably meet with disagreement from the several authors of this book. It is difficult, however, to reach any other conclusion. Diagnosis is explicit in Miss Wallerstein's discussion when she quotes herself (p. 91) as saying to a worker, ''This man's problem is not that of a refugee; this is a man with a very serious personality difficulty.'' It is apparent again (p. 92) when she ably differentiates the client whose difficulty arises from his recent experiences from one who presents difficulties that are merely crystallized or accentuated by his experiences, and so on. This point is not made in a spirit of controversy, but because the reviewer, and undoubtedly other nonfunctional case-workers, cannot fully understand the disparaging attitude toward diagnosis that appears in the *Introduction* (pp. 7–8) and in previous publications by functional case-workers.

Mrs. Levinson's article is valuable from two points of view. It is helpful in formulating the effects on giver and taker of charging a fee for case-work services. It is also a warning to us to become more expert in transferring experience. As one reviews this article, the author's findings have a familiar ring. When the worker gives money and the client accepts it, we are awake to the different meanings money has, the different uses to which people put it. Here, in receiving money *for* a service just as when we give it *as* a service, we find money used to bribe, control, evade, to bestow love or to elicit it.

The high point in Miss Marcus' article is her statement (p. 151) that the professional purpose underlying the case-work method is the purpose ''of helping the conscious ego or self of the client to preserve its place and its function in the social scheme from the hazards associated with a need beyond the individual's own capacity to meet.'' This seems far more adequate than Dr. Taft's comment (p. 6) that ''it is the function and structure of the social agency that differentiates the helping that belongs to social case-work from the helping found in therapy.'' While Miss Marcus' article contains several points not entirely clear to the nonfunctional worker, perhaps the one most in need of clarification is related to the client's conflicts. Is it a correct interpretation of functional method to infer that the case-worker must help the client to keep his ambivalences conscious, but that it is not her obligation to help him resolve them? Or is the emphasis on assisting the client to resolve conflicts about *using* help rather than on the conflicts that precipitated him into *needing* help? Or does the functional worker equate the struggles ''inherent in the using of case-

work help'' with the ''struggle . . . waged against the conflicting feelings that beset him in finding and pursuing his purpose''?

Miss Robinson's case illustrations follow naturally upon Miss Marcus' article. They are unusual examples of a worker's support of whatever healthy ego the client possesses. This, and all other publications from the functional group, inevitably raise the question whether the functional method is suited to any but a fundamentally well-organized ego. Even allowing for differences in skill, which are quite apparent in the cases throughout the volume, one can doubt whether clients should be exposed to a head-on collision such as Mrs. Green is met with in Mr. Gromberg's article (pp. 120–21).

The nonfunctional worker is perhaps incurable in his insistence that function, as used in many cases that appear in this series and in the *Journal of Social Work Process,* has a restrictive and punitive aspect that is not inherent in the understanding and use of agency purpose, policy, and procedure.

JEANETTE REGENSBURG.
Tulane University School of Social Work,
New Orleans, Louisiana.

PSYCHIATRY FOR NURSES. By Louis J. Karnosh, M.D., and Edith B. Gage, in collaboration with Dorothy Mereness. Second edition. St. Louis: The C. V. Mosby Company, 1944. 339 p.

In this, the second edition of *Psychiatry for Nurses,* the two original authors have had the collaboration of a third, Dorothy Mereness. The pleasing features of the first edition have been retained. The paper is white and the type plain. There are 29 chapters, a glossary, and 38 photographs and diagrams. A few of the diagrams are new and some of the photographs have been improved.

Visual aids to learning are effective, and many nurses are said to be eye-minded. Important details may be taught by presenting desirable settings in photographs. If all nurses could see the exquisite care that is given to hyperactive and acutely psychotic patients in hospitals that cherish the best nursing standards, patients in less favored institutions would benefit.

In this volume there are photographs that tend to confirm the popular concept of a mental patient as a fantastic, wild-eyed creature, untidily dressed and with disordered hair. Pictures of patients, especially those on pages 119, 124, and 137, show a neglect of personal grooming and an untidiness that would appear to be unnecessary and that reflect on the nursing. Patients need not be left to sit on the floor in dark corners, as is the patient shown on page 118. Not many

patients need to be dressed in strong material, but if such a garment is necessary, it looks better when neatly arranged.

Patients with acute symptoms occasionally may need to be restrained, for the protection of themselves or others. Whenever this is necessary, due regard for the patient should be shown, and only sufficient force should be used to accomplish the necessary objective. On page 125, the patient being restrained by two other persons is held in an uncomfortable position and in a few hours is likely to have bruises on her wrists and forearms. Patients in a continued bath need not be restrained by a canvas tub cover, as shown on page 269. If the patient shown an page 293 has a severe convulsion, the end of the tongue depressor may be bitten through, endangering the patient's safety.

For students whose introduction to psychiatry is made elsewhere than in the Cleveland City Hospital—with the neuropsychiatric division of which the authors are connected—explanation of some of the words or ideas presented in this textbook may be needed. For example, in the preface this sentence occurs: "Some of the principles of psychiatry are a radical departure from those of orthodox medical practice."

In Chapter 2, on heredity and mental disease, one finds the following statements: "For example, if a deaf-mute mates with a normal person, none of the offspring will be abnormal. If two deaf-mutes marry, they will have all deaf-mute children" (p. 29). "If only one of the parents has an affective psychosis, over 30 per cent of the children will have the same disorder" (p. 31). Environment is not listed among the causes of mental diseases.

In Chapter 6, *Examination of the Mental Patient,* item 7, covering habits, includes only the use of alcohol, tobacco, and drugs. Eating, sleeping, recreation, and everyday activities might have been listed as habits, and the special three addictions mentioned might have been classed as habitual use of stimulants.

In Chapter 7, which deals with the admission of patients, the text does not make it clear that the procedure described is the practice in a particular institution. Patients, like other folk, are at a disadvantage when they are deprived of their teeth and glasses; when these items are confiscated as a routine practice, as happens in some institutions, this is done so that the hospital will not be liable for their loss or breakage. In private hospitals, patients are not usually so inconvenienced. The classification of mental diseases given is referred to as "the one offered by Meyer." Dr. Meyer's first name is spelled "Adolph" on page 86, but it is given correctly in the index.

The chapter on psychiatry and the law and that on mental hygiene, the last two in the book, are interesting. They would be more effective

if they had been introduced earlier, and they could have been amplified to advantage. References and questions for review follow each chapter.

As a supplement to individual opinion, student nurses with experience in psychiatric nursing through affiliation at a well-known hospital were asked for their estimate of the usefulness of the book to them. The replies of three of them may be summarized as follows: Two said that the book is helpful and makes their nursing care of patients more interesting; essential information is readily located and comprehensible. One student thought that the definitions of psychoses lack clarity; for instance, the statement that "acute mania is very much like hypomania, but the condition is more intense," leaves her confused. Another would like "more detail . . . manner of approach . . . recreational . . . occupational . . . other therapies that are best" for patients with different psychoses. Their instructor says that the text is liked by the instructors and that they use it freely as a reference book.

Psychiatry for Nurses will be helpful to student nurses attending the lectures and classes that it is written to accompany.

MARY E. CORCORAN.

U. S. Public Health Service, Bethesda, Maryland.

NOTES AND COMMENTS

Death of Dr. Mary Vanuxem

It is with deep regret that The National Committee for Mental Hygiene announces the death of Dr. Mary Vanuxem, who for the last two years had contributed her services to the Committee as editor of the "Notes and Comments" section of Mental Hygiene. Dr. Vanuxem was stricken with coronary thrombosis on November 2, at her summer home in Lake Mohawk, New Jersey, and died three days later in the hospital at Franklin, New Jersey.

Born in Camden, New Jersey, Dr. Vanuxem was educated in private schools, in the West Chester (Pennsylvania) State Teachers College, the University of Pennsylvania, and Columbia University, where she received not only her B.S., but her A.M. and her Ph.D. She became associate supervisor of practice at the Newark (New Jersey) State Teachers College, and then head of the department of psychology at the Philadelphia Normal School, and lecturer at the Women's Medical College, Philadelphia.

In 1920 she received an appointment as psychologist at Laurelton State Village, Laurelton, Pennsylvania, and in 1922 she became assistant superintendent there, a position that she held until her retirement in 1942. Laurelton Village was the great interest of Dr. Vanuxem's life and to it she gave freely of her abounding energy and vitality. She planned in great detail the educational work of the village, along both academic and industrial lines, and initiated a parole system that has continued to the present time with great success. In addition to her other work, she conducted research for fifteen years on the children of mentally defective women at the village.

Upon her retirement in 1942, she became a volunteer worker with the New York State Committee on Mental Hygiene and assisted in organizing and supervising the Medical Survey Program for the Selective Service. In the fall of 1943, she added to her voluntary duties the editing of the "Notes and Comments" section of Mental Hygiene, a service that she performed faithfully until her death.

Dr. Vanuxem was a fellow of the American Association for Mental Defectives and of the American Association for the Advancement of Science, and a member of the American Psychological Association, and she had been appointed by the National Research Council to their Subcommittee on Mental Defectives. She was the author of a number of publications in the field of mental deficiency.

Dr. Vanuxem's warm friendliness had won her a place with the staff of The National Committee for Mental Hygiene quite out of proportion to the relatively short period of her association with them. Her death has left them with a sense of real personal loss. Its suddenness was an added shock, as she had been in the office, apparently in perfect health, only a day or two before she was stricken. Yet one feels that she went as she herself would have chosen to go—still active and useful, still full of interest and enthusiasm, still eager to contribute in any way that she could to the work in which she believed.

"When the Greeks made their fine saying that those whom the gods love die young," wrote Robert Louis Stevenson, "I cannot help believing they had this sort of death also in their eye. For surely, at whatever age it overtake the man, this is to die young."

Thirty-Sixth Annual Meeting of the National Committee for Mental Hygiene

The National Committee for Mental Hygiene held its Thirty-Sixth Annual Meeting at the Hotel Waldorf-Astoria, New York City, on Thursday and Friday, November 1 and 2. The success of the 1944 meeting, with its two-day session of papers and discussions in addition to the annual luncheon, led the Committee to adopt the same type of program for this meeting, and again the large attendance—over a thousand people—testified to the widespread interest in the topics under discussion. Fortunately this year large enough quarters had been secured to accommodate every one who came.

The program opened with a session on "Prejudice," at which Dr. S. Bernard Wortis, Director of the Bellevue Psychiatric Hospital, New York City, acted as chairman. Three papers were presented—*Merits and Men,* by Lieutenant Colonel Julius Schreiber, of Washington, D. C.; *Human Factors in Job Discrimination,* by Caroline K. Simon, Commissioner, New York State Commission Against Discrimination, New York City; and *Dispelling the Bogey,* by Robert Norton, Secretary of the League for Fair Play, New York City.

The annual luncheon meeting of the National Committee followed, Mr. Eugene Meyer, editor and publisher of the *Washington Post* and President of The National Committee for Mental Hygiene, presiding. Dr. George S. Stevenson, Medical Director of the National Committee, presented his report, and General Omar N. Bradley, Administrator of Veterans Affairs, Veterans Administration, Washington, D. C., spoke on "Protecting the Health of the Veteran."[1]

[1] See pages 1–8 of this issue of Mental Hygiene.

General Bradley also presented the Lasker Award in Mental Hygiene,[1] which this year was divided between two outstanding leaders in the field of rehabilitation—Dr. John Rawlings Rees, formerly Consultant in Psychiatry in the British Army, with the rank of brigadier; and Major General G. Brock Chisholm, Deputy Minister of National Health, Federal Department of National Health and Welfare, Ottawa, Canada.

The business meeting of The National Committee for Mental Hygiene was held immediately after the luncheon.

The second session of the day was given up to accounts of some new technical developments in psychiatry and mental hygiene, with Dr. Frank Fremont-Smith, Medical Director of the Josiah Macy, Jr. Foundation, New York, serving as chairman. Lieutenant Colonel John M. Murray, of Boston, described some new developments in psychotherapy; and Dr. M. Ralph Kaufman, recently with the armed forces in the Pacific, presented a paper on "A Therapeutic Program in Combat." Lieutenant Commander Howard P. Rome, of the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., spoke on "Moving Pictures as a Medium of Education"; and Commander William A. Hunt, also of the Navy Department's Bureau of Medicine and Surgery, on "New Evaluative Methods and Future Prospects."[2]

The topic of the morning session of the second day, with Dr. Ellen C. Potter, Director of Medicine of the New Jersey Department of Institutions and Agencies, as chairman, was "Federal Mental-Hygiene Activities." The three papers were *Psychiatric Plans of the United States Public Health Service,* by Dr. Robert H. Felix, Medical Director, Mental Hygiene Division, U. S. Public Health Service, Washington, D. C.; *Protecting and Promoting the Mental Health of the Child Via the Children's Bureau,* by Dr. Martha Eliot, Associate Chief, U. S. Department of Labor, Children's Bureau, Washington, D. C.; and *Rehabilitation and Mental Handicaps,* by Mary E. Switzer, Assistant to the Administrator, Federal Security Agency, Washington, D. C.

Major General G. Brock Chisholm delivered the address at the luncheon that followed, at which Dr. Samuel W. Hamilton, Mental Hospital Advisor, Mental Hygiene Division, U. S. Public Health Service, presided. Dr. Chisholm's subject was "World Peace and Mental Health."

Another feature of the luncheon was the presentation of the prizes offered by *The Modern Hospital* for the three best essays on the topic, "A Plan for Improving Hospital Treatment of Psychiatric Patients." Dr. Robert N. Felix presented the awards. The first

[1] See pages 114–21 of this issue of MENTAL HYGIENE.

[2] See pages 9–32 of this issue of MENTAL HYGIENE.

prize, of $500, went to Lieutenant L. L. Hasenbush, Medical Corps, U.S.N.R., formerly resident psychiatrist at Johns Hopkins Hospital and instructor in psychiatry at Johns Hopkins University; the second prize, of $350, to Gerald Victor Haigh, formerly connected with Boys' Village, and at present serving as an attendant at the Norwich State Hospital, Norwich, Connecticut, under the mental-hygiene program of Civilian Public Service; and the third prize, of $150, to Captain K. R. Eissler, Chief of Consultation Service, Camp Fannin, Ward Officer Regional Hospital, Fort Jackson, South Carolina. Captain Eissler was born in Vienna, Austria, and received his medical education there. Prior to his entry into military service, he had been in private practice in this country.

Four other papers received honorable mention in the contest: one by Major Stanley Stellar, of Groton, Massachusets; one by Dr. George N. Preston, State Commissioner of Mental Hygiene, Baltimore, Maryland; one by Francis B. Rice, of Siloam Springs, Arkansas; one by Milton Lozoff, M.D., U.S.N.R. (psychiatrist on leave from the Menninger Clinic, Topeka, Kansas) and Marjorie Morse Lozoff, of Milwaukee, Wisconsin; and one by Lieutenant Commander Howard P. Rome, M.C., U.S.N.R., and Lieutenant Commander Robert S. Wigton, M.C., U.S.N.R., both of the Bureau of Medicine and Surgery of the Navy Department, Washington, D. C.

The purpose of the contest was to promote interest in a concrete plan for improving the hospital treatment of psychiatric patients, so that as many as possible can be returned to community life.

The final session of the meeting carried on the theme of *The Modern Hospital* competition—"Improved Facilities for Psychiatric Patients." Dr. Daniel Blain, Medical Director, Recruitment and Manning Organization of the War Shipping Administration, presided. Dr. Nolan D. C. Lewis, Director, New York State Psychiatric Institute and Mental Hospital, and Director of Research in Dementia Præcox, The National Committee for Mental Hygiene, presented a paper on "What's What About Shock Treatment." Dr. Luther E. Woodward, Field Consultant of the Committee's Division on Rehabilitation, spoke on "A Permanent Medical Survey"; and Dr. Thomas A. C. Rennie, Director of the Division on Rehabilitation, and Associate Professor of Psychiatry of the Cornell University Medical School, discussed "National Planning for Psychiatric Education."

The National Committee for Mental Hygiene is planning another two-day program for its Thirty-Seventh Annual Meeting next November.

National Committee for Mental Hygiene and American Psychiatric Association Form Nation-wide Placement Service

The two leading national organizations in the field of psychiatry have united to help meet the critical situation in which the country finds itself as a result of psychiatric problems arising out of the war. In the field of psychiatry, which has always been short of well-trained personnel, there are literally thousands of places in which psychiatrists are needed. There also are thousands of medical men who had some experience in psychiatry during the war, and who are now seeking training opportunities.

As an initial step in bringing the psychiatrically trained and psychiatrically minded medical men in touch with the opportunities, the American Psychiatric Association, the oldest specialty society in America, founded more than one hundred years ago, has joined forces with The National Committee for Mental Hygiene, the pioneer organization in the field of mental health, which was founded in 1909. The following official announcement has been made by the two organizations:

"The American Psychiatric Association and The National Committee for Mental Hygiene jointly announce the appointment of Captain Forrest M. Harrison (M.C.), U.S.N., as director of a newly established Psychiatric Personnel Placement Service. The service is designed especially to help physicians and psychiatrists make contacts with training opportunities such as residencies, postgraduate courses, and fellowships, and to aid institutions in locating suitable candidates for appointments. Physicians interested in psychiatry are invited to send in full biographical statements, including personal data, education, training, experience, and special desires, in order that this service may be of the greatest possible assistance to them.

"Deans of medical schools, superintendents of hospitals, and directors of industrial organizations, clinics, and others employing or participating in the training of psychiatric personnel are invited to submit full information regarding available positions and courses, including financial details.

"Foundations, universities, and other agencies are asked to report pertinent fellowships in psychiatry, psychosomatic medicine, and child guidance.

"Inquiries should be addressed to Captain Forrest M. Harrison (M.C.), U.S.N., The National Committee for Mental Hygiene, 1790 Broadway, New York City 19."

Field Representative for State Work Appointed by National Committee for Mental Hygiene

Progress in mental hygiene, state by state, is a twofold task. On the one hand, it is a task of organizing the informed citizenry of the state so that they can give support and leadership to those elements that are determined within the state. Beyond that it is a matter of national activity for such matters as general legislation, training of personnel, and literature. The National Committee for Mental Hygiene, therefore, is interested in strengthening intra-state resources and has added to its staff a field representative to carry that particular function. The immediate motive is the organization of state resources in order that rehabilitation of the mentally handicapped may be furthered, but the same process will, of course, affect every aspect of mental-hygiene work in a state. Mr. Justin Reese, who for several years has been identified with mental-hygiene activities, has been appointed field representative for this purpose.

Reprint Service of Josiah Macy, Jr., Foundation Discontinued

More than five million copies of over four hundred leading medical and scientific articles have been published by the Josiah Macy, Jr., Foundation's War Reprint Service during the last three years, for medical officers of the armed forces of the United States and, in so far as possible, Canada, England, New Zealand, Australia, the Union of Socialist Soviet Republics, and China, according to a recent statement by Dr. Willard C. Rappleye, president of the foundation. Dr. Rappleye stated further that with the plans for demobilization of the armed forces, the reprint service would be discontinued by January 1.

The reprint service of the foundation has been an effort to bring new and important developments in the science and practice of medicine to medical officers who were largely cut off from the sources of medical information during the war. In the selection of these articles, the foundation has had the active coöperation of The National Committee for Mental Hygiene and of the Committee on Pathology of the National Research Council. The articles selected for reprint and distribution were those dealing with the most recent scientific developments that had a direct bearing on medical and health problems related to military service. The distribution to the medical officers was worked out in coöperation with the surgeons general of the army and navy and the air surgeon. Through the courtesy of The National Committee for Mental Hygiene, more than one million reprints were delivered to neuropsychiatric medical officers.

In addition to the articles reproduced from journals, the founda-

tion has published for the air surgeon five original monographs, prepared by medical officers of the army air forces, dealing with personality disturbances occurring in combat zones. Over 95,000 copies of these monographs were distributed by the reprint service as official documents of the Office of the Air Surgeon. Eight additional monographs and nine reviews of medical literature on subjects of military interest have been prepared and 70,000 copies distributed. Since August, 1944, a news letter for the Rheumatic Fever and Streptococcus Control Program of the Army Air Forces has been published monthly for the air surgeon, and over one thousand copies each month have been mailed to interested medical officers, military hospitals, and medical-school libraries. Through the coöperation of the interdepartmental Committee on Cultural and Scientific Coöperation of the Department of State, 60,000 reprints have been distributed to medical teachers and investigators in forty-eight foreign countries. The Office of War Information requested permission to circulate the foundation's reprints among more than thirty of their foreign outposts, and has reduplicated selected articles for their distribution to medical leaders abroad.

Dr. Rappleye stated that the foundation has expended over $225,000 in financing the war reprint service.

A Quarterly Review of Psychiatry and Neurology

In response to an ever-increasing demand, the Washington Institute of Medicine, 1720 M Street, N. W., Washington 6, D. C., publishers of a number of well-known quarterly reviews of world literature in various medical fields, has decided to add to their list a review of psychiatry and neurology. The new review, which will appear in January, April, July, and October, will be edited by Dr. Winifred Overholser, Superintendent of St. Elizabeths Hospital and professor of psychiatry at George Washington University, with the assistance of a board of other outstanding authorities in the field.

The material will be gathered from every authoritative source, including more than four hundred medical journals, transactions of meetings, special bulletins of hospitals and clinics, and so forth. Each issue will contain a cross-reference subject index and an author index, and the October issue of each year will include a cumulative subject-and-author index.

Those who wish a complete file of the review are urged to subscribe promptly. Because of the cost of the publication, no more copies will be printed than are required for actual subscribers, so it is unlikely that back issues will be available. The subscription price is $9.00 a year.

Broadened Psychiatric Nursing Services

As an initial step in its extensive post-war editorial expansion program, the *American Journal of Nursing* has appointed to its staff a new assistant editor, much of whose time and attention will be concentrated upon developments in the field of psychiatric nursing.

Edith Patton, the new editor (B.A., Smith College; M.N., Western Reserve) will bring to her important new assignment an experience that began at the Westchester Division of the New York Hospital in White Plains as staff nurse and assistant night supervisor, and includes services at Massachusetts General Hospital and Norwich (Conn.) State Hospital as assistant supervisor, instructor in psychiatric nursing, and assistant director of nursing in charge of education.

Prior to her appointment, Miss Patton's name had become familiar to the nation's nurses through her contributions to the *Journal*. Papers published in 1945 include *Psychiatric Nursing in the General Hospital* and *Psychiatric Conditions Encountered in the General Hospital*. In close touch with activities and progress in her specialty, she will fill for nurses the long-felt need for more complete and practical information covering many aspects of a subject of fast-mounting professional and public importance.

The *American Journal of Nursing* is the official publication of the American Nurses' Association, and its growing editorial and research staffs are composed exclusively of graduate nurses.

A Refresher Course in Psychiatry at University of California Medical School

The Division of Psychiatry of the University of California Medical School is offering a refresher course in psychiatry for doctors returning from military service. The course will run for twelve weeks, beginning January 7. Dr. Karl M. Bonman, Director of the Langley-Porter Clinic and professor of psychiatry, University of California Medical School, directs the instruction, with the assistance of staff members from other divisions of the medical school.

The subjects to be covered include general psychiatry, functional and organic psychoses, psychoneuroses, therapy, psychosomatic problems, neuroanatomy, clinical neurology, neuropathology, X-ray diagnosis, and other related topics.

The course is open to graduates of approved medical schools with nine months of general internship, preference being given to applicants with training in psychiatry, to those preparing for examinations by the American Board of Psychiatry and Neurology, to graduates of the University of California Medical School, and to legal residents of the state of California.

The fee for the course is $200, payable in advance.

For further information write to University Extension, University of California, 540 Powell Street, San Francisco 2, California.

Course in Psychosomatic Medicine Offered at Temple University

Temple University Medical School and Hospital is offering to a limited number of qualified physicians a course in psychosomatic medicine. The course, which will extend from March 4 to 20, is designed to assist internists and practitioners of general medicine in the diagnosis and management of psychoneurotic and psychosomatic conditions. It is not intended for specialization in psychiatry.

The course will consist of lectures, seminars, conferences, and clinical work in wards and out-patient departments. The work will be closely supervised and special lecturers who have had exceptional experience both in civilian and in military neuropsychiatry and psychosomatic medicine will participate in the teaching program. The fee for the course is $200. Applications should be made to Mrs. Carol Krusen Scholz, Registrar for Psychosomatic Course, Temple University Hospital, 3401 North Broad Street, Philadelphia 40, Pennsylvania.

A Clinical Fellowship in Pastoral Care

The Institute of Pastoral Care has announced that Reverend James H. Burns, of Princeton, Massachusetts, has been awarded a clinical fellowship in pastoral care, to begin January 1, 1946. This is the first time such a fellowship has been offered by the institute, and it will provide both teaching and research opportunities in the field of ministering to individuals. Reverend Mr. Burns will study under the direction of Reverend Rollin J. Fairbanks, Protestant chaplain at the Massachusetts General Hospital and director of the institute.

New York City Announces Examination for School Psychiatrist

The Board of Examiners of the New York City Board of Education announces examinations for the license of school psychiatrist at the Bureau of Child Guidance, to be held in March, 1946. The position carries the advantages of civil-service tenure and a liberal retirement pension. The salary starts at $6,000 and rises to $7,000 in three years.

The general requirements are: age between thirty and forty-five; graduation from a Grade A medical college, and either (a) five years of practice in psychiatry, including 800 hours in an approved mental institution and 1,200 hours in an approved child-guidance

clinic, or (b) three years of practice in psychiatry, including 1,200 hours in an approved mental institution and 1,200 hours in an approved child-guidance clinic.

Further information about these requirements and the examinations may be obtained upon application. The final date for filing applications is February 25, 1946. Application forms may be obtained in person, or by writing to Board of Examiners, Room 437, Board of Education, 110 Livingston Street, Brooklyn 2, New York. The written request must be accompanied by a large, self-addressed envelope bearing 6 cents in stamps.

Radcliffe College Invites Application for Helen Putnam Fellowship

Radcliffe College invites application for the Helen Putnam Fellowship for Advanced Research in the general field of genetics or of mental health. The fellowship, carrying a stipend of $2,000, and covering a period of eleven months, from October 1, 1946, is open to mature women scholars who have gained their doctorate, or possess similar qualifications, and who have research in progress. Applications for the award must be submitted to Radcliffe College not later than April 1, 1946.

All normal laboratory facilities will be provided to the winner of the Putnam Fellowship, whose appointment will be announced about May 1 by the Committee on Award, which includes President W. K. Jordan, of Radcliffe, and the following members of the Harvard University Faculty: Arlie V. Bock, M.D., professor of hygiene; Stanley Cobb, M.D., professor of neuropathology and psychiatrist-in-chief at the Massachusetts General Hospital; Alden B. Dawson and Leigh Hoadley, professors of zoölogy; Karl Sax, professor of botany; and Edwin B. Wilson, professor of vital statistics, emeritus.

Dr. Lewis Appointed Adviser to International War Crimes Tribunal

Dr. Nolan D. C. Lewis, Director of the New York State Psychiatric Institute and Hospital, and Director of Research in Dementia Præcox for The National Committee for Mental Hygiene, has been appointed psychiatric adviser to the International War Crimes Tribunal, and has left for Nuremberg, Germany, where the trial of war criminals is now taking place. Dr. Lewis will serve as the representative of the United States on the psychiatric board.

Commander Daniel Blain Becomes Director of Neuropsychiatric Services of Veterans Administration

Commander Daniel Blain, of New York, detailed during the war by the United States Health Service as psychiatrist with the War Shipping Administration in New York City, has been appointed Director of the Neuropsychiatric Services of the Veterans Administration.

Commander Blain will direct and supervise the activities of the three branches of neuropsychiatry—psychiatry, neurology, and mental hygiene. He will be responsible also for directing the psychiatric care and treatment of veterans suffering from neuropsychiatric disabilities, who at present make up 61 per cent of all patients under the care of the Veterans Administration.

Commander Blain will also supervise the establishment of additional mental-hygiene clinics and will formulate the regulations under which they function. This program is rapidly expanding in the Veterans Administration, with present plans calling for mental-hygiene clinics in each of the 54 regional offices.

A strong advocate of the new psychiatry, which can be employed to advantage in an informal residential type of psychiatric center, Commander Blain has helped many torpedoed and shipwrecked seamen recover from neuropsychiatric troubles and return to duty.

Annual Meeting of the American Orthopsychiatric Association

The American Orthopsychiatric Association will hold its 1946 meeting at the Hotel New Yorker, New York City, on February 14, 15, and 16. Information with regard to the program may be secured from the secretary of the association, Miss Nina Ridenour, Room 916, New York 19, N. Y.

Centennial of First U. S. Institution for Mental Defectives

Plans have been definitely made to hold a centennial celebration of the establishment of the first institution for mental defectives in the United States in 1848 in Boston. Dr. Stanley Raymond, of the American Association on Mental Deficiency, is chairman in charge of the celebration of this centennial. Further details will be made public later.

A Plea from the Philippines

An appeal from Manila for "help in any manner or form" has been called to our attention by Dr. Edward J. Humphreys, Chief of the Bureau of Mental Hygiene, Division of Mental Diseases, Ohio

State Department of Public Welfare. The appeal comes in a letter written to Dr. Humphreys last April by Dr. Jose A. Fernandez, of the National Psychopathic Hospital, Mandaluyong, Manila. Dr. Fernandez describes the desperate straits to which the population of Manila and his hospital were reduced by the Japanese occupation and the shelling of the city, and asks for any aid that may be forthcoming. He mentions especially the need for psychiatric books and journals, as everything of that nature was lost when the hospital library was destroyed among other buildings.

Dr. Humphreys sends on the letter with the suggestion: "If there is any way by which readers of your journal could be of assistance in the restoration of the National Psychopathic Hospital in Manila, I am sure that such assistance will contribute to the development of closer relationships with the people of the Philippines."

Experience Speaks

The following letter from a man who has had eighteen years of experience with an artificial limb is reprinted from the Washington *Times-Herald* of November 14:

> "I think that it is about time to tell the public the other side of the story about artificial limbs. The articles so far printed have very little, if any, experienced background.
>
> "By that I mean the authors of these articles have only worn artificial limbs a short time, maybe a year or maybe a week. Some have never worn limbs at all.
>
> "One is hardly qualified to make any statement either way unless he has worn a limb long enough to know how it stands the strain of everyday use. As for myself, I have been wearing two artificial limbs, both above the knee, 7- and 9-inch stumps, for nearly 18 years. I know how they work and how they wear.
>
> "I have a regular position, like most any other physically perfect man. I stand on my feet about five hours a day doing spray painting. I am also active in sports, as I bowl, pitch baseball, hunt, and fish. When you tramp over five miles of ground, hunting, your limbs are under more strain than 100 times normal walking on sidewalks. The strain of twisting the joints when you bowl or throw a baseball is terrific.
>
> "My limbs stand that pressure.
>
> "I have worn four pairs of limbs in eighteen years, and the ones I have now will last at least four more years. This averages five and a half years at the least. My other limbs didn't wear out—I outgrew them as I became older. With the experience I have had, I can say that the limbs are strong and will stand a lot of punishment.
>
> "You must take into consideration that you wouldn't beat your natural leg around. Therefore, if you treat your artificial limb as a natural limb, it will give you years of satisfaction.
>
> "As for the squeaks that cause embarrassment (as one writer gave as one fault), the answer is simple. If you don't oil your car or any other mechanical device, it will become noisy. What's the difference?

You wash your natural limb to keep it clean so as not to have dirt sores collect and cause little use of the limb.

"Well, just bathe your artificial limb with oil at the joints ever so often and your answer is there.

"There have been improvements in the industry in the past 25 years. Metal limbs have been perfected for lightness. Hip control has been installed on above-knee limbs so as to do away with about six feet of straps over your back and shoulders, such as my first pair had; and there are many other things that add to more comfort in an artificial limb.

"There has been talk about limbs being too heavy. Mine weigh 7½ pounds each. That is considered a little better than average weight for an above-knee limb. They do not tire me, and as for myself, another couple pounds would come in handy in windy weather, as they are light at 7½ pounds and hard to handle in windy weather.

"The shape of these limbs is perfect. A lady wearing stockings can stand in front of a person without being detected that she is wearing an artificial limb. The same is true of a man. Of course, if the limb is not covered, it is noticeable only by the joints and color. But who wants to run around without stockings, anyway?

"As for the price, well, $150 to $250 is just a trifle considering the benefit you derive from the appliance. And you must remember there is a lot of skilled labor involved in the manufacture of the limb. As for me, I wouldn't be without mine."

(Signed) HARRY E. ASHBAUGH

GROUP CARE OF YOUNG CHILDREN

The following fourteen points to be considered in the group care of young children were formulated by Mrs. Lili E. Peller, lecturer at the School of Education, City College, New York City, and published in the *Bulletin of the New York Association of Day Nurseries,* June 6, 1945. They are reprinted here by permission of the *Bulletin.*

"*Physiological Needs.* The basis of the nursery day should be satisfaction of the child's need to eat, to exercise vigorously indoors and out, and to rest in an atmosphere free from pressure, anxiety, and hurry. The same applies to elimination. Satisfaction of the physiological needs provides the very young child with basic gratifications and is also the starting point for intelligent interest in his surroundings. The satisfaction of these needs should be planned with the maximum of understanding of age-level needs.

"(Formerly we believed that the young child had a strong tendency to steer away from the things which were good for him, like regularity in meals, in sleep, and in elimination; from lots of sleep, drinking of water, eating of spinach. We thought that mother and teacher had to work hard in order 'to train him right.' To-day we still see many discrepancies between the requirements of physical hygiene and the child's own choice, but the studies by A. Freud, C. Davis, A. Aldrich, A. Gesell, *et al.* indicate this gap could be narrowed by more careful observations of children.)

"*Relationship with Adults.* The nursery should be staffed with people who are serene and affectionate, who like children and are able to accept them as they are. If adults are to have warmth and understanding for children, those adults themselves should work in an atmosphere of cordial coöperation. Their work must offer them a certain minimum of professional and financial satisfaction. (We have not deviated—we are still speaking about the needs of children, for *children* need contented adults around them.)

"The child's moral and spiritual development is nursed by the warmth, the loyalty, and the optimism of the adults with whom he lives. He needs stable and lasting relationships with adults as well as with children, and, therefore, needs small groups. The teacher should not change after one semester, or the child be uprooted by placing him in another group the day he becomes three or four years of age.

"*Sense of Achievement.* The child needs a set-up conducive to the feeling of adequacy, competence, success. As often as possible let children have the experience: I Can Do It!

"He wants to grow out of babyhood, and the nursery school can help him in a twofold way: (1) By lessening the pressure to discard childish behavior patterns which is so strong in our culture. Queer as it may seem, this pressure not only takes the spurt and joy out of his development, but pressure also may make him cling apprehensively to infantile gratifications. (2) By providing him with avenues to proceed towards grown-upness at his own rate.

"*Companionship.* He needs the company of other children approximately his own age; at times he needs to be, not in a group, but with one or two children only or all by himself.

"*Exploring the Environment.* There should be materials to manipulate, to explore. Touching, pounding, squeezing, pouring, crumbling, etc., just for its own sake! Materials which can be handled in an unconventional way, where his initiative, his inventiveness, his desire 'to produce' find fertile ground.

"*Play Leading Deeper and Further.* His play helps him to adjust to this world. Playing, he repeats what he has experienced and this imaginative reliving helps him to digest events and emotions which were upsetting, frustrating, or unexpected. Therefore, his spontaneous dramatic play should be as free as possible of adult restrictions and also of adult interference originating in well-meaning, but ill-placed sentimentality.

"He needs music, rhythms, dance, songs, rhymes, stories, colors. Art and music appreciation are an essential part of the program, but his appreciation is not a motionless 'taking-in.' It is always an active participation, mixed with self-expression. Even when listening to a story, he will carry out movements suggested by it. He 'listens' best to music when dancing or humming.

"*Absence of Rushing.* He needs to be unhurried—throughout his nursery-school day. When he is absorbed by his play, his 'work,' we should think twice before interrupting him. He needs long stretches of playtime without interruption.

"While activity is his obvious need, he also has the desire to be plain idle at times, or to dilly-dally in some way.

"*Self-Selection.* He needs to make his own choice often—with *whom* and *what* to play and *where* and how to do it.

"*The Need for 'Inconsistent' Behavior.* The child needs to go back and forth between behavior patterns impressing us as babyish, and others which are rather grown-up and carry prestige in his and his friends' eyes.

"*Repetition.* He needs the security of familiar patterns. The same general sequence of events daily puts him at ease. Familiar tunes, stories, rhymes, pictures, games, chants, and verbal formulas are a source of delight.

"*Curiosity.* He also craves new experiences. His inquisitiveness indicates a real need to widen his intellectual territory. Although his stay in nursery school cuts him off from many experiences he might have in his home, the nursery school can do more than make up for this.

"He needs to do things which are a real challenge; a chance for activities taking courage and giving the feeling of *daring.* Foremost, at this age, for several reasons: climbing. (But also the lighting of birthday candles, carrying a jar filled with water or milk, etc.)

"*High Lights.* Besides the steady daily resurging rhythm, he needs occasional peaks like trips, visits to other groups, festivals, dressing-up, and birthday parties. The older children especially need something that can be anticipated, that's breath-taking while it happens, and talked about and remembered afterwards. The older pre-school child likes to follow a project for several days—for instance, block-building. When he finishes a painting, it should go into a folder with his name on it and accessible to him. He loves to look at drawings or at clay work he did so 'long ago.' This need for projects running into time is as vital with the five-year-old as life on a pure 'cash' basis is for the two- or three-year-old.

"*Personal Belongings.* These are particularly essential when his school day is long.

"*Behavior Deviations.* The child with special needs should be recognized and helped early."

News of Mental-Hygiene Societies

Hawaii

The Mental Hygiene Society of the Territory of Hawaii is interested in securing the services of a full-time paid executive secretary. This is a new position. The salary will be $350.00 a month, advancement depending upon the growth of the society and its work. The duties are to guide, to stimulate, and to promote the development of an integrated program for the society, which is now three years old, with major emphasis upon education, coördination, and publicity. The requirements include training and experience in psychiatric social work, with demonstrated ability in public relations preferred. Candidates with training and successful experience in community organization will also be considered. Selection will be made on the basis of an unassembled examination which will include submission of a short thesis on a pertinent subject. For particulars write immediately, clipper mail, to Miss Vivian Johnson, c/o Territorial Society for Mental Hygiene, Mabel Smyth Building, Honolulu, T. H.

Ohio

The latest state society to be organized is the Ohio Mental Hygiene Association, which was formed at a meeting in Columbus, November 23, by a representative number of civic, professional, church, labor, rural, welfare, and mental-health leaders.

Serving as chairman is the Reverend Dr. D. R. Sharpe, Executive Secretary of the Cleveland Baptist Association and Executive Vice-President of his city's Community Relations Board. Dr. Sharpe is a nationally known churchman and religious writer, prominent in the affairs of his state, who has been acknowledged as Ohio's most successful crusader for improving the care of the mentally ill.

Although the Ohio Mental Hygiene Association plans to secure as competent professional guidance as is possible, its founders intend that its emphasis be upon the layman, all efforts being made to secure a mass membership of a "grass-roots" nature.

Although stressing veterans rehabilitation activities, the association also plans to conduct a public campaign designed to secure larger legislative appropriations for state institutions. It already has secured a commitment from the state administration to this effect. In addition to having the support of established mental-hygiene groups, the association has been successful in obtaining the backing of important labor, rural, church, and civic groups.

The Ohio Mental Hygiene Association was formed with the assistance of The National Committee for Mental Hygiene.

New Publications

Some of the situations that may arise when the ex-service man returns to a home in which there are young children are discussed in a 32-page booklet, *Father Comes Home,* prepared by the staff of the Child Study Association of America, 221 West 57th Street, New York 19, N. Y., in coöperation with the U. S. O. Division, National Board, Y. W. C. A., 600 Lexington Avenue, New York 22, N. Y. Entertainingly written and amusingly illustrated, the booklet offers suggestions as to ways of dealing with the awkward moments that are likely to be encountered before the children have adjusted to the "stranger" who has suddenly been injected into the family life, and before he, in his turn, has adjusted to a household in many ways different from the household that he left when he entered the service.

Copies of the booklet may be obtained from the Child Study Association of America, at a price of 15 cents a copy. Discounts are made on large orders.

The Illinois Society for Mental Hygiene has issued in pamphlet form the proceedings of the two-day institute on "Readjusting With the Returning Servicemen," which was held last March in Chicago under the society's auspices. The pamphlet, which has the same title as the institute, can be obtained from the Illinois Society for Mental Hygiene, 243 South Dearborn Street, Chicago 4, Illinois. The price is $1.25 a copy.

Case Work With Ill and Disabled Servicemen is the title of an attractive little brochure made up of four articles by Cynthia Rice Nathan—*Service to Amputees; Social Service to Plastic Surgery Cases; Servicemen and Tropical Diseases* (Parts I and II); and *Servicemen Face Discharge With Hope and Fear.* The articles were originally printed in *The Family.* Copies of the brochure, at 40 cents a copy, can be obtained from the Family Welfare Association of America, 122 East 22nd Street, New York 10, N. Y.

Under the title *Youth Centers—An Appraisal,* the Federal Agency's Recreation Division, Office of Community War Services, has issued a report on the teen-age centers that have sprung up all over the United States since the start of the war. The report tells how these clubs—of which there are now more than 3,000, serving about a million boys and girls—are initiated and how they are operated and paid for, and gives practical information on facilities, programs, rules, and regulations, based on a sampling of 300 representative teen-age clubs. It also gives an evaluation of these clubs by recreation specialists, and discusses their relationship to other community programs for youth. Illustrated with photographs of youth centers in full swing, it should serve as a guide both to new and to already existing community clubs for young people. Single copies can be obtained from the Recreation Division of the Office of Community War Services, Federal Security Agency.

Requests are often received for literature on the teaching and training of backward children in the home, but little has been written on the subject. A real need is, therefore, met by an attractive little booklet recently issued by the Division of Public Institutions of the State of Minnesota—*Teach Me; A Guide for Parents and Others Who Have the Care of Subnormal Children.* The topics discussed include habit-training, discipline, lessons, emotions, looks and manners, and so forth. The suggestions offered are concrete and practical and are presented simply and clearly. For further information about the booklet, write the Mental Health Unit, Division of Public Institutions, Department of Social Security, St. Paul, Minnesota.

A set of leaflets containing the five talks given in the radio series on mental hygiene sponsored by the Cleveland Mental Hygiene Association early in 1945 may be obtained from the association's office, 1101 Swetland Building, Cleveland 15, Ohio. Single copies of the set will be supplied upon request without charge. The talks are *The Basis of Mental Health,* by Dr. Henry C. Schumacher; *The Parent and the Happy Child,* by Mrs. James D. Polley; *Guiding Teen Age Youth in Home and School,* by Dr. Bertha M. Luckey; *Better Mental Health for Ohio Citizens,* by Dr. Frank F. Tallman; and *What the Community Can Do to Aid the Returning Service Man,* by Dr. Joseph Fetterman.

CURRENT BIBLIOGRAPHY *

Compiled by

EVA R. HAWKINS

The National Health Library

Ackerman, Nathan W., M.D. What constitutes intensive psychotherapy in a child guidance clinic. American journal of orthopsychiatry, 15:711–20, October 1945.

Adams, Elsie G., M.D. Narco-analysis in private practice. Diseases of the nervous system, 6:343–47, November 1945.

Adler, Alexandra, M.D. Two different types of post-traumatic neuroses. American journal of psychiatry, 102:237–40, September 1945.

Alexander, George H., M.D. Therapeutic efficacy of electroconvulsive therapy: a comparative classification of treatment results determined with and without the use of a time factor in their evaluation. Journal of nervous and mental disease, 102: 221–30, September 1945.

Alt, Herschel. Child guidance in the post-war period. Child welfare league of America, Bulletin, 24:4–7, September 1945.

American psychiatric association. Committee on psychiatric standards and policies. Standards for psychiatric hospitals and out-patient clinics approved by the American psychiatric association (1945–46). American journal of psychiatry, 102: 264–69, September 1945.

Anderson, John E. Shall my child go to nursery school? National parent-teacher, 40:4–6, December 1945.

Appel, Kenneth E., M.D. Nationalism and sovereignty: a psychiatric view. Journal of abnormal and social psychology, 40:355–62, October 1945.

Arieti, Silvano, M.D. Primitive habits in the preterminal stage of schizophrenia, with particular reference to the hoarding and self-decorating habits. Journal of nervous and mental disease, 102:367–75, October 1945.

Arsenian, John. The paradoxical effects of the "quota system." Psychiatry, 8:261–65, August 1945.

Auerbach, Frank L. Inter-country case work. Family, 26:221–26, October 1945.

Bahr, Max A., M.D. Psychiatry "comes of age." Public welfare in Indiana, Indiana state department of public welfare, 55:11–14, October 1945.

Banay, Ralph S., M.D. Cultural influences in alcoholism. Journal of nervous and mental disease, 102: 265–75, September 1945.

Barbato, Lewis, M.D. The state mental hospital—an educational center. Diseases of the nervous system, 6: 269–75, September 1945.

Barbour, Richmond. A substitute for the rod. Nation's schools, 36:28–29, November 1945.

Barry, Herbert, Jr., M.D. Incidence of advanced maternal age in mothers of one thousand state hospital patients. Archives of neurology and psychiatry, 54:186–91, September 1945.

Bartemeier, Leo H., M.D. Recent civilian experiences with psychiatric rehabilitation. Proceedings of the Royal society of medicine, Section of psychiatry (London), 38:680–81, October 1945.

Beaumont, Arlene L. Psychotherapy of children by social case workers. Smith college studies in social work, 15:259–86, June 1945.

Beigel, Hugo G. How to know your child: to be of real help you must learn to read the signs and signals a child sends out. Parents' magazine, 20:15, 106–8, 110, 112, October 1945.

Bellak, Leopold, M.D. On the psychology of detective stories and related problems. Psychoanalytic review, 32:403–7, October 1945.

Bender, Lauretta, M.D. Infants reared in institutions permanently handicapped. Child welfare league of America, Bulletin, 24:1–4, September 1945.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Benton, Arthur L. The Minnesota multiphasic personality inventory in clinical practice. Journal of nervous and mental disease, 102:416–20, October 1945.

Bergler, Edmund, M.D. A short genetic survey of psychic impotence. II. Psychiatric quarterly, 19:657–76, October 1945.

Bergler, Edmund, M.D. Synchronization of neurotic behavior patterns. American journal of the medical sciences, 210:470–80, October 1945.

Bergler, Edmund, M.D. "Working through" in psychoanalysis. Psychoanalytic review, 32:449–80, October 1945.

Berliner, Bernhard, M.D. Short psychoanalytic psychotherapy. Bulletin of the Menninger clinic, 9:155–61, September 1945.

Betz, Barbara J., M.D. A psychiatric children's ward. American journal of nursing, 45:817–21, October 1945.

Bick, John W., Jr., M.D. The problem of the severe psychoneurotic in the army air forces. American journal of psychiatry, 102:222–30, September 1945.

Binger, Carl A. L., M.D. A critique of psychosomatic medicine. Rhode Island medical journal, 28:642–46, 665, September 1945.

Binger, Carl A. L., M.D. A critique of psychotherapy in arterial hypertension. Bulletin, New York academy of medicine (New York City), 21:610–15, November 1945.

Blaine, Mary. Helping children speak. Hygeia, 23:736–37, 784, October 1945.

Bleckwenn, William J., M.D. Neuroses in the combat zone. Annals of internal medicine, 23:177–83, August 1945.

Bossard, James H. S. What can we do about divorce? National parent-teacher, 40:4–6, October 1945.

Brill, Norman Q., M.D., Tate, M. C. and Menninger, W. C., M.D. Enlisted men with overseas service discharged from the army because of psychoneuroses: a follow-up study. Mental hygiene, 29:677–92, October 1945.

Bro, Margueritte H. Parents can be people. Child study, 23:13–15, Fall 1945.

Brodman, Keeve, M.D., Mittelmann, Bela, M.D. and Wolff, H. G., M.D. Psychologic aspects of convalescence: XX. Journal of the American medical association, 129:179–87, September 15, 1945.

Bullen, Adelaide K. A cross-cultural approach to the problem of stuttering. Child development, 16:1–88, March–June 1945.

Bunker, Henry A., M.D. "Repression" in prefreudian American psychiatry. Psychoanalytic quarterly, 14:469–77, October 1945.

Burgess, Ernest W. Unemployment and the family. Marriage and family living, 7:87, 89, 94–95, Autumn 1945.

Burns, George C. Neuropsychiatric problems at an Aleutian post. American journal of psychiatry, 102: 205–13, September 1945.

Burns, Maudie M., M.D. Diagnosis and treatment of behavior problems. Connecticut health bulletin, State department of health, 59:179–80, August 1945.

Bychowski, Gustav, M.D. Some aspects of shock therapy: the structure of psychosis. Journal of nervous and mental disease, 102: 338–56, October 1945.

Camargo, Oswaldo, M.D. and Preston, G. H., M.D. What happens to patients who are hospitalized for the first time when over sixty-five years of age. American journal of psychiatry, 102:168–73, September 1945.

Cameron, Eugenia S. K., M.D. Mental health problems in school. Wisconsin state board of health, Quarterly bulletin, 7:15–17, July–September 1945.

Campbell, Coyne H., M.D. A brief critique of psychosomatics. Ohio state medical journal, 41:805–9, September 1945.

Carlson, Edith F. Project for gifted children: a psychological evaluation. American journal of orthopsychiatry, 15:648–61, October 1945.

Case histories of compulsive drinkers. Foreword by N. D. C. Lewis, M.D. Edited by Carney Landis and J. F. Cushman. Quarterly journal of studies on alcohol, 6:139–82, September 1945.

Casey, Jesse F., M.D. Disciplinary problems in a military neuropsychiatric hospital. Military surgeon, 97:312–17, October 1945.

Chaplin, Doris. The young delinquent. American journal of psychiatry, 102: 257–59, September 1945.

Cohen, Benjamin, M.D. and Swank, R. L., M.D. Chronic symptomatology of combat neuroses. War medicine, 8:143–45, September 1945.

Colby, Mary R. The responsibility of a state department of public welfare in adoption: evaluation and interpretation. Social service review, 19:352–58, September 1945.

Condell, Lucy. The story hour in a neuropsychiatric hospital. Library journal, 70:805–7, September 15, 1945.

Cooley, Jean M. The relative amenability of dull and bright children to child guidance. Smith college studies in social work, 16:26–43, September 1945.

Coomaraswamy, Ananda K. "Spiritual paternity" and the "puppet-complex"; a study in anthropological methodology. Psychiatry, 8: 287–97, August 1945.

Corcoran, Mary E. Psychiatric nursing experience by affiliation. Public health reports, U. S. Public health service, 60:1237–43, October 19, 1945.

Coriat, Isador H., M.D. Some aspects of a psychoanalytic interpretation of music. Psychoanalytic review, 32:408–18, October 1945.

Cronin, John W., M.D., Solby, Bruno, M.D., and Wilder, W. S., M.D. An industrial mental hygiene program for federal employees. Public health reports, U. S. Public health service, 60:1323–36, November 9, 1945.

Culpin, Millais, M.D. Psychology in medicine. Lancet (London), 249: 517–20, October 27, 1945.

Current trends in counseling; a symposium. Marriage and family living, 7:82–86, Autumn 1945.

Contents: Counseling with the returned serviceman and his wife, by C. R. Rogers.—Methods for effective counseling, by R. L. Dicks. —Counseling in the premarital interview, by S. B. Wortis, M.D.

Curtis, Dorothy E. The patients in car D. American journal of nursing, 45:804–7, October 1945.

Davidson, G. M., M.D. Further observations on hallucinations of smell. Psychiatric quarterly, 19:692–96, October 1945.

Davison, Charles, M.D. Psychological and psycho-dynamic aspects of disturbances in the sleep mechanism. Psychoanalytic quarterly, 14:478–97, October 1945.

de Grazia, Sebastian. A note on the psychological position of the chief executive. Psychiatry, 8:267–72, August 1945.

Donaldson, Helen M. and Mayberg, G. C. Co-operation between a veterans hospital and a family agency. Parts I–II. Family, 26:208–15, October 1945.

Draper, George, M.D. On certain biological factors in human disease. Bulletin, New York academy of medicine (New York City), 21:599–609, November 1945.

DuBois, Eloise B. Building self-confidence: when a child finds he can do a number of things without assistance he feels a healthy self-assurance. Parents' magazine, 20: 18–19, 90, 93–94, 96, October 1945.

Eidelberg, Ludwig, M.D. Psychoanalysis of a case of paranoia. Psychoanalytic review, 32:373–402, October 1945.

Eldred, Donald M. Vermont's program for psychoneurotics. Journal of rehabilitation, 11:31–33, September 1945.

Eliasberg, Wladimir, M.D. Institutionalizing the obsessive psychopath. Psychiatric quarterly, 19:697–701, October 1945.

Erb, Howard R., M.D. and Bond, D. D., M.D. Sodium amytal narcosis in management of emotional disorders of combat flyers. War medicine, 8:146–52, September 1945.

Evans, Harrison S., M.D. and Ziprick, H. F., M.D. Minor psychiatric reactions in officers. War medicine, 8:137–42, September 1945.

Farber, Leslie H., M.D. and Micon, Leonard, M.D. Gastric neurosis in a military service. Psychiatry, 8: 343–61, August 1945.

Favreau, Claire H. Existing needs in psychiatric nursing. American journal of nursing, 45:716–17, September 1945.

Favreau, Claire H. Opportunities in psychiatric nursing. Public health reports, U. S. public health service, 60:1233–37, October 19, 1945.

Feldman, Sandor S., M.D. Dr. C. G. Jung and national socialism. American journal of psychiatry, 102:263, September 1945.

Feldman, Sandor S., M.D. Interpretation of a typical and stereotyped dream met with only during psychoanalysis. Psychoanalytic quarterly, 14:511–15, October 1945.

Feldman, Sandor S., M.D. True and false conceptions of psychoanalysis. Psychiatric quarterly, 19:566–85, October 1945.

Fisher, Charles, M.D. Amnesic states in war neuroses: The psychogenesis of fugues. Psychoanalytic quarterly, 14:437–68, October 1945.

Fisher, Mary S. Young families in transition. Child study, 23:3–4, 36, Fall 1945.

Fodor, Nandor. The hero's rebirth. Psychoanalytic review, 32:481–98, October 1945.

Fodor, Nandor. The negative in dreams. Psychoanalytic quarterly, 14:516–27, October 1945.

Folsom, Joseph K. When and how to say no. National parent-teacher, 40:16–18, October 1945.

Fox, Henry M., M.D. Insulin for rehabilitation. Bulletin of the U. S. Army medical department, 4:447–52, October 1945.

Foxe, Arthur N., M.D. Science and awareness. Journal of nervous and mental disease, 102:454–60, November 1945.

Frankel, Emil. Neuropsychiatric screening of selective service registrants in New Jersey. Journal of the Medical society of New Jersey, 42:268–73, August 1945.

Franklin, Zilpha C. Working mothers —where do they go from here? Child study, 23:8–12, Fall 1945.

Freeman, Henry. Case work with relatives of patients who are leaving a mental hospital. Public welfare, American public welfare association, 3:153–56, July 1945.

Frender, Lena. Handicapped children and their problems. Understanding the child, 14:118–19, October 1945.

Gardner, George E., M.D. and Goldman, Nathan. Childhood and adolescent adjustment of naval successes and failures. American journal of orthopsychiatry, 15:584–96, October 1945.

Gaskill, Herbert S., M.D. Marihuana, an intoxicant. American journal of psychiatry, 102:202–4, September 1945.

Geisel, John B. Discipline reconsidered. School and society, 62:193–95, September 29, 1945.

Gibson, Robert, M.D. A conjectured correlation between depressions of the manic-depressive and involutional melancholic types and ethnic elements in the present-day population of Britain. American journal of psychiatry, 102:164–67, September 1945.

Ginsburg, Ethel L. The case worker in a Veterans' service center. Family, 26:264–71, November 1945.

Goitein, P. Lionel, M.B. and Brown, E. A., M.D. Asthma and solitude; a study of the asthmatic incarcerate. Journal of nervous and mental disease, 102:501–5, November 1945.

Goldensohn, Leon N., M.D., Clardy, E. R., M.D. and Levine, K. N. Schizophrenic-like reactions in children. (Second series.) Psychiatric quarterly, 19:592–604, October 1945.

Goldfarb, Walter, M.D. and Kiene, H. E., M.D. The treatment of the psychotic-like regressions of the combat soldier. Psychiatric quarterly, 19:555–65, October 1945.

Goldthwait, Marjorie. A navy psychiatric department in England. Trained nurse and hospital review, 115:261–64, October 1945.

Good and bad mental hygiene in education as seen by teachers and school administrators. Understanding the child, 14:120–24, October 1945.

Goodfellow, H. D. L. Training defectives in institutions. Canadian nurse (Montreal), 41:787–92, October 1945.

Gralnick, Alexander, M.D. A fatality incident to electroshock treatment; review of the subject and autopsy report. Journal of nervous and mental disease, 102:483–95, November 1945.

Gray, Elizabeth J. Service to mental hospitals. Survey midmonthly, 81:231–33, September 1945.

Greenebaum, Jacob V., M.D. and others. Effects of encephalitis occurring during childhood on behavior and personality: a study of fifty cases. Ohio state medical journal, 41:1018–21, November 1945.

Greiber, Marvin F., M.D. Narcosynthesis in the treatment of the noncombatant psychiatric casualty overseas. War medicine, 8:85–90, August 1945.

Gurvitz, Milton S. An alternate short form of the Wechsler-Bellevue test. American journal of orthopsychiatry, 15:727–32, October 1945.

Hacker, Frederick J., M.D. and Geleerd, E. R., M.D. Freedom and authority in adolescence. American journal of orthopsychiatry, 15:621–30, October 1945.

Hackett, Wally R. Child care as a means of group therapy. American journal of orthopsychiatry, 15:675–80, October 1945.

Haggard, Howard W., M.D. The physician and the problem of alcoholism. Bulletin, New York academy of medicine, 21:451–66, September 1945.

Haggard, Howard W., M.D. The "wets" and "drys" join against science. (Editorial.) Quarterly journal of studies on alcohol, 6:131–34, September 1945.

Hakeem, Michael. Glueck method of parole prediction applied to 1,861 cases of burglars. Journal of criminal law and criminology, 36:87–97, July–August 1945.

Hakeem, Michael. Prediction of criminality. Federal probation, 9:31–38, July–September 1945.

Hamilton, Samuel W., M.D. Psychiatric hospitals have six chances to serve. Modern hospital, 65:65–66, September 1945.

Hansen, A. V., Jr., M.D. A study of 50 veterans of World war II admitted to the Philadelphia general hospital psychiatric building. Diseases of the nervous system, 6:348–50, November 1945.

Hardesty, Amelia. Teaching job organization to new workers in a public agency. Family, 26:226–33, October 1945.

Harms, Ernest. Socio-psychiatric aspects of war and post-war neuroses. Diseases of the nervous system, 6: 285–88, September 1945.

Hellersberg, Elisabeth F. The Horn-Helersberg test and adjustment to reality. American journal of orthopsychiatry, 15:690–710, October 1945.

Hildreth, Harold M. and Hill, J. M., M.D. A neuropsychiatric questionnaire for group examining. U. S. naval medical bulletin, 45:895–902, November 1945.

Hoffman, L. W. Court-school relationships. Federal probation, 9:27–30, July–September 1945.

Holden, Marcia. Treatability of children of alcoholic parents. Smith college studies in social work, 16: 44–61, September 1945.

Holla, William A., M.D. Mental hygiene clinics. New York state journal of medicine, 45:2012, 2014, September 15, 1945.

Holt, Robert R. Effects of ego-involvement upon levels of aspiration. Psychiatry, 8:299–317, August 1945.

Houwink, Eda. Case work by telephone. Family, 26:261–64, November 1945.

Howe, Hubert S., M.D. Trial by ordeal—from a neuropsychiatrist's viewpoint. Industrial medicine, 14: 702–4, September 1945.

Jaques, Elliott. The clinical use of the thematic apperception test with soldiers. Journal of abnormal and social psychology, 40:363–75, October 1945.

Jenkins, Richard L., M.D. The constructive use of punishment. Mental hygiene, 29:561–74, October 1945.

Jennings, Dana C. What can be done for the spastic child? Hygeia, 23: 834–37, 864, 866, 868, November 1945.

Johnson, D. E. and Thickstun, J. T. Fraternity in combat. American journal of psychiatry, 102:245–56, September 1945.

Johnson, Eleanor H. Reminiscences of World war I: Base hospital 117. American journal of orthopsychiatry, 15:607–20, October 1945.

Johnson, Marguerite W. Language and children's behavior. Elementary school journal, 46:141–45, November 1945.

Johnston, William C. B., M.D. and others. A method of psychological screening of naval offenders. Military surgeon, 97:300–6, October 1945.

Joseph, Marjorie-Lee and Kramer, Nanette. How good a mother are you? Hygeia, 23:734–35, October 1945.

Kahn, Samuel, M.D. Suggestion. Medical record, 158:608–10, October 1945. (To be continued.)

Kalz, Frederick G., M.D. Psychological factors in skin disease. Canadian medical association journal (Montreal), 53:247–53, September 1945.

Kant, Otto, M.D. Types of psychiatric casualty in the armed forces. Mental hygiene, 29:656–65, October 1945.

Kaplan, Lawrence I. and others. Acute psychosis following therapeutic malaria in a case of neurosyphilis: report of a case. Journal of nervous and mental disease, 102: 285–89, September 1945.

Katz, Julius, M.D., Plunkett, R. E., M.D. and Thompson, M. E. Prevalence of pulmonary tuberculosis in New York state institutions for the mentally ill. Psychiatric quarterly, 19:644–56, October 1945.

Kawin, Ethel. The contribution of Adolf Meyer and psychobiology to child guidance. Mental hygiene, 29: 575–90, October 1945.

Kazan, A. T. and Sheinberg, I. M. Clinical note on the significance of the validity score (F) in the Minnesota multiphasic personality inventory. American journal of psychiatry, 102:181–83, September 1945.

Keeling, Dorothy C. Answering a nation's "quiz." Family, 26:233–35, October 1945.

Kelman, Harold, M.D. Neurotic pessimism. Psychoanalytic review, 32: 419–48, October 1945.

Kemble, Robert P. Do we need schools for psychiatry? American journal of orthopsychiatry, 15:733–36, October 1945.

Kemp, Milburn W., M.D. Conflicts and psychogenic maladjustments incidental to age. Minnesota medicine, 28:715–17, September 1945.

Kennedy, Foster, M.D. War neurosis as it is related to psychosomatic medicine. New York state journal

of medicine, 45:2285–90, November 1, 1945.

Kerman, Edward F., M.D. Electroshock therapy, with special reference to relapses and an effort to prevent them. Journal of nervous and mental disease, 102:231–42, September 1945.

Klapman, J. W., M.D. Posthospitalization supportive psychotherapy. Psychiatric quarterly, 19:605–17, October 1945.

Knight, Robert P., M.D. The use of psychoanalytic principles in the therapeutic management of an acute psychosis. Bulletin of the Menninger clinic, 9:145–54, September 1945.

Kosmak, George W., M.D. Psychosomatic aspects of gynecology and obstetrics. New York state journal of medicine, 45:2298–2304, November 1, 1945.

Kubie, Lawrence S., M.D. The value of induced dissociated states in the therapeutic process. Proceedings of the Royal society of medicine, Section of psychiatry (London), 38: 681–83, October 1945.

Kutash, Samuel B. A comparison of the Wechsler-Bellevue and the revised Stanford-Binet scales for adult defective delinquents. Psychiatric quarterly, 19:677–85, October 1945.

LaBarre, Weston. Some observations on character structure in the Orient: the Japanese. Psychiatry, 8:319–42, August 1945.

Langdon, Grace. Truthfulness and honesty—taught or caught? National parent-teacher, 40:21–23, October 1945.

Laycock, Samuel R. Psychotherapy for the general practitioner. Canadian medical association journal (Montreal), 53:230–35, September 1945.

Lemkau, Paul V. and Kent, F. E. Sociological factors in patients in army neurosis center and their relation to disciplinary actions. American journal of psychiatry, 102: 231–36, September 1945.

Lennox, William G., M.D. The epileptic—who he is: what he can be. Journal of rehabilitation, 11:3–8, September 1945.

Leonard, Lucille P. Together we build good citizenship. National parent-teacher, 40:33–34, December 1945.

Lippman, Hyman S., M.D. Treatment of juvenile delinquents. Social service review, 19:373–80, September 1945.

Lipschutz, Louis S., M.D. The background of military psychoneuroses. Military surgeon, 97:384–88, November 1945.

Löwi, Moritz, M.D. and Cohen, L. H., M.D. Comprehension-defects in the psychoses. Journal of abnormal and social psychology, 40:391–400, October 1945.

Lowinger, Louis and Huddleson, J. H., M.D. Outcome in dementia præcox under electric shock therapy, as related to mode of onset and to number of convulsions induced. Journal of nervous and mental disease, 102:243–46, September 1945.

MacLean, Paul D., M.D., Moore, Merrill, M.D. and Crocker, David, M.D. Tropical psychiatry. Bulletin of the U. S. Army medical department, 4: 551–53, November 1945.

MacNaughton, Ernest B. Hard facts. I–II. Oregon health bulletin, State board of health, 23:3–4, August 8, 1945; 3–4, August 15, 1945.

McSwain, E. T. Common sense in teaching. National parent-teacher, 40:17–19, December 1945.

Mahler, Margaret S., M.D., Luke, J. A., M.D. and Daltroff, Wilburta, M.D. Clinical and follow-up study of the tic syndrome in children. American journal of orthopsychiatry, 15:631–47, October 1945.

Mamet, Bernard M. Constitutionality of compulsory chemical tests to determine alcoholic intoxication. Journal of criminal law and criminology, 36:132–47, July–August 1945.

Margaretten, Isidore, M.D. Nervousness. Hygeia, 23:752–53, 784, October 1945.

Marmor, Judd and Zander, A. F. Psychological problems in training 16 and 17 year old youths in the United States Maritime service. American journal of orthopsychiatry, 15:571–83, October 1945.

Masserman, Jules H., M.D. Psychiatry, mental hygiene, and daily living. Mental hygiene, 29:650–55, October 1945.

Menninger, William C., M.D. Psychosomatic medicine on general medical wards. Bulletin of the U. S. Army medical department, 4:545–50, November 1945.

Miller, Horace G., M.D. The psychic trauma of becoming part of a group. Diseases of the nervous system, 6: 280–82, September 1945.

Mitchell, Eileen. Young offenders. Canadian welfare (Ottawa), 21: 32–38, October 15, 1945.

Mittelmann, Bela, M.D. Psychoanalytic observations on dreams and

psychosomatic reactions in response to hypnotics and anaesthetics. Psychoanalytic quarterly, 14:498–510, October 1945.

Montagu, Montague F. A. The physical characters of African and other non-American Negroids. Psychiatry, 8:279–85, August 1945.

Moore, Merrill, M.D. Recurrent nightmares: a simple procedure for psychotherapy. Military surgeon, 97: 282–85, October 1945.

Morris, J. Z. The school superintendent and mental hygiene. Understanding the child, 14:110–14, October 1945.

Morrow, Joseph L., M.D. Treatment in an army neuropsychiatric hospital. Military surgeon, 97:388–94, November 1945.

Mott, Sina M. Muscular activity an aid in concept formation. Child development, 16:97–109, March–June 1945.

Mukerjee, Radhakamal. Social disguise as the principle of art. Sociology and social research, 30:3–10, September–October 1945.

Muncie, Wendell, M.D. Foster homes for adults. Journal of nervous and mental disease, 102:477–82, November 1945.

Needles, William. A statistical study of one hundred neuropsychiatric casualties from the Normandy campaign (with control material). American journal of psychiatry, 102: 214–21, September 1945.

Neumann, Frederika. The use of psychiatric consultation by a case work agency. Family, 26:216–21, October 1945.

Neuropsychiatric number. Hospital corps quarterly, 18:1–64, September 1945.

Ostow, Mortimer, M.D. and Ostow, Miriam. The frequency of blinking in mental illness: a measurable somatic aspect of attitude. Journal of nervous and mental disease, 102: 294–301, September 1945.

Owen, Joseph W., M.D. and others. Treatment of combat fatigue in a forward-area hospital. U. S. naval medical bulletin, 45:611–20, October 1945.

Owens, Robert H. The neuropsychiatric dischargee: a sample study of the pre-induction school records and post-service records of men discharged from the army because of nervous or mental conditions. Mental hygiene, 29:666–76, October 1945.

Palmer, Harold, M.D. Military psychiatric casualties: experience with 12,000 cases. Lancet (London), 249: 454–57, October 13, 1945; 492–94, October 20, 1945.

Peabody, Katherine E. [illegible]upational therapy and psycl[illegible] in the treatment of ulcerat[illegible]olitis. Occupational therapy [illegible] rehabilitation, 24:163–67, Au[illegible] 1945.

Pearson, Grosvenor B., [illegible] Research in psychiatry. Mode[illegible]ospital, 65: 79–80, October 1945.

Pedersen, Thyra E. The fenestration operation for otosclerosis: psychological factors. American journal of nursing, 45:726–27, September 1945.

Pennington, L. A. The incidence of nail-biting among adults. American journal of psychiatry, 102:241–44, September 1945.

Perlson, Joseph, M.D. A critical appraisal of the mental examination in state hospitals. Journal of nervous and mental disease, 102:404–11, October 1945.

Peters, Mary O. A client writes the case record. Family, 26:258–61, November 1945.

Pinco, Joyce. Helping a disturbed veteran. Family, 26:271–74, November 1945.

Plant, James S., M.D. Emerging problems for the pediatrician. Texas reports on biology and medicine, 3: 263–70, Fall 1945.

Plass, Herbert F. R., M.D. Emotional albuminuria in returned flying officers. War medicine, 8:153–55, September 1945.

Poley, Irvin C. The kind of parent teachers like. Child study, 23:5–7, Fall 1945.

Power, Thomas D., M.D. Psychosomatic regression in therapeutic epilepsy. Psychosomatic medicine, 7: 279–90, September 1945.

Prescott, Daniel A. and others. The child study process at work: a study of fantasy. Understanding the child, 14:99–109, October 1945.

Price, Henrietta G. and Corcoran, Lois. Work therapy in a private neuropsychiatric hospital. Occupational therapy and rehabilitation, 24:155–59, August 1945.

Rains, Sybil W. Don't hurry the baby. Parents' magazine, 20:15, 79–80, November 1945.

Reeves, Grace. The new family in the postwar world. Marriage and family living, 7:73–76, 89, Autumn 1945.

Rennie, Thomas A. C., M.D. Needed: 10,000 psychiatrists. Mental hygiene, 29:644–49, October 1945.

Reynolds, Whitman M. When father comes home again: the children are older—different—and so is father. Learning [illegible] live together again takes p[illegible] and understanding. Parents' n[illegible]ine, 20:28, 70–72, 74–76, 78, O[illegible] 1945.

Roland, Ma[illegible] Help for problem children. [illegible]on's schools, 36:25–27, Novem[illegible]n 1945.

Roman, Robert and Landis, Carney. Hallucinations and mental imagery. Journal of nervous and mental disease, 102:327–31, October 1945.

Rome, Howard P., M.D. The neuropsychiatric problem in returning servicemen. Diseases of the nervous system, 6:333–36, November 1945.

Rubenstein, Ben. Therapeutic use of groups in an orthopædic hospital school. American journal of orthopsychiatry, 15:662–74, October 1945.

Ruesch, Jurgen, M.D. and Bowman, K. M., M.D. Prolonged post-traumatic syndromes following head injury. American journal of psychiatry, 102: 145–63, September 1945.

Ruskin, Dave B., M.D. Epidemiology of tuberculosis in a mental hospital. American review of tuberculosis, 52: 248–57, September 1945.

Ryder, Margaret B. Case work with the aged parent and his adult children. Family, 26:243–50, November 1945.

Salmon, David R. An essential approach to rehabilitation. New York state journal of medicine, 45:1972–73, September 15, 1945.

Santulli, Mary L. Criteria for selection of families for housekeeper service. Smith college studies in social work, 15:327–46, June 1945.

Saul, Leon J., M.D. Psychological factors in combat fatigue, with special reference to hostility and the nightmares. Psychosomatic medicine, 7:257–72, September 1945.

Schneck, Jerome M., M.D. A bibliography on bibliotherapy and libraries in mental hospitals. Bulletin of the Menninger clinic, 9:170–74, September 1945.

School social workers. Understanding the child, 14:115–17, October 1945.

Schreiber, Julius, M.D. The interdependence of democracy and mental health. Mental hygiene, 29:606–21, October 1945.

Segal, Charles. Functional aspects of military social case work. American journal of orthopsychiatry, 15:597–606, October 1945.

Senn, Milton J. E., M.D. Emotional aspects of convalescence: fulfillment of child's emotional needs is factor in physical as well as psychological recovery. Child, U. S. Children's bureau, 10:24–28, August 1945.

Sevringhaus, Elmer L., M.D. and Chornyak, John, M.D. A study of homosexual adult males. Psychosomatic medicine, 7:302–5, September 1945.

Shirley, Mary M. and Poyntz, Lillian. Children's emotional responses to health examinations. Child development, 16:89–95, March–June 1945.

Shorvon, H. J., M.B. Use of benzedrine sulphate by psychopaths: the problem of addiction. British medical journal (London), p. 285–86, September 1, 1945.

Shryock, Harold, M.D. Alcohol and mental crack-ups: a physician paints a picture the liquor ads never show. Life and health, 60:18–19, 35, October 1945.

Shryock, Harold, M.D. Moods, mental depression, melancholy. What causes them? Can we escape them? Life and health, 60:16–17, 25, 27, September 1945.

Sinclair, Alexander J. M., M.D. The psychological reactions of soldiers. Medical journal of Australia (Sydney), 2–32nd yr.: 229–34, August 25, 1945; 261–69, September 1, 1945.

Slavson, S. R. Treatment of withdrawal through group therapy. American journal of orthopsychiatry, 15:681–89, October 1945.

Smith, Alson J. Alcoholics are people. Mental hygiene bulletin, Michigan society for mental hygiene, 4:1–3, No. 2, 1945.

Smith, Lauren H., M.D. and Wood, H. C., M.D. The general practitioner and the returning veteran. Journal of the American medical association, 129:190–93, September 15, 1945.

Social planning and community planning integrated in Grand Rapids project. Mental hygiene bulletin, Michigan society for mental hygiene, 4:5–6, No. 2, 1945.

Sontag, Lester W., M.D. The purpose and fate of a skin disorder. Psychosomatic medicine, 7:306–10, September 1945.

Spiegel, Herbert X., M.D., and others. An hypnotic ablation technique for the study of personality development: a preliminary report. Psychosomatic medicine, 7:273–78, September 1945.

Spock, Benjamin M., M.D. Avoiding behavior problems. Journal of pediatrics, 27:363–82, October 1945.

Steckel, Harry A., M.D. Psychiatric implications of internal medicine. Psychiatric quarterly, 19:636–43, October 1945.

Stein, Sam I., M.D. Psychiatric cross section perspectives viewed through juvenile court cases. Journal of nervous and mental disease, 102: 440–48, November 1945.

Stern, Margery. Some differences between neurotic delinquents and other neurotic children. Smith college studies in social work, 16:62–81, September 1945.

Stevens, Harold, M.D. Psychoses among women government workers in wartime. American journal of psychiatry, 102:260–62, September 1945.

Strauss, Bernard V., M.D. What constitutes intensive therapy in a child guidance clinic. American journal of orthopsychiatry, 15:721–26, October 1945.

Strecker, Edward A., M.D. Psychiatry speaks to democracy. Mental hygiene, 29:591–605, October 1945.

Strengthening family living [Collection of articles]. Childhood education, 22:59–96, October 1945.

Struthers, A. M. Juvenile delinquency in Scotland. American sociological review, 10:658–62, October 1945.

Symposium on the problem of alcoholism in postwar planning. Quarterly journal of studies on alcohol, 6:183–255, September 1945.

Introduction, by E. M. Jellinek.—New legislation for the control of alcoholism: the Connecticut law of 1945, by S. D. Bacon.—The attitude of industrial management toward alcoholism, by Clemens Mortenson. —Screening inebriates in municipal courts, by Lewis Drucker.—The physician and the alcoholic, by H. W. Haggard, M.D.—The rôle of the church and the pastor in postwar alcoholism, by O. F. Blackwelder.—The alcoholic in the penal institution, by H. B. Gill.—Alcoholics Anonymous in a postwar emergency, by W. W.—A note on drinking in the college community, by C. C. Fry, M.D.—The citizen's part in the problem of alcoholism, by Marty Mann.

Tallman, Frank F., M.D. Recent legislation and its effect on Ohio's mental hygiene program. Ohio state medical journal, 41:1028–30, November 1945.

Taylor, Louis. The social adjustment of the only child. American journal of sociology, 51:227–32, November 1945.

Thénaud, Agnes. Survey of requests for day nursery care, with reference to post-war planning. Smith college studies in social work, 15: 287–326, June 1945.

Thimann, Joseph, M.D. Mental hygiene in the rehabilitation of alcoholics. Bulletin, Massachusetts society for mental hygiene, p. 1–3, July 1945.

Thomas, Dorothy V. The veteran as seen in a private family agency. Family, 26:203–8, October 1945.

Thomas, Preston W., M.D. Character and the psychopath. Journal of nervous and mental disease, 102: 449–53, November 1945.

Thompson, Clara, M.D. Transference as a therapeutic instrument. Psychiatry, 8:273–78, August 1945.

Thompson, George N., M.D. Physical manifestations in mental disease. Journal of nervous and mental disease, 102:280–84, September 1945.

Tompkins, Charles A., M.D. Preventive care of infants and children. 1. The first postnatal family interview. American journal of diseases of children, 70:32–39, July 1945.

The treatment of our mentally ill. (Reprint of article issued by the Wisconsin citizens' public welfare association.) Welfare bulletin, Illinois state department of public welfare, 36:13, 16–17, 22, October 1945.

Troxell, M. A., M.D. Psychosomatic medicine, with special reference to the neurodermatoses. Minnesota medicine, 28:718–22, September 1945.

Tucker, William E. The consideration of functional disabilities in orthopædics. Proceedings of the Royal society of medicine (London), 38: 613–16, September 1945.

Tunbridge, Ronald E., M.D. Psychiatric experiences of a general physician in Malta 1941–43. Lancet (London), 249:587–90, November 10, 1945.

U. S. Surgeon general's office. Neuropsychiatry for the general medical officer. Mental hygiene, 29:622–43, October 1945.

Verin, Olga. Racial attitudes of Negro clients. Smith college studies in social work, 16:1–25, September 1945.

von Hentig, Hans. The delinquency of the American Indian. Journal of

criminal law and criminology, 36: 75–84, July–August 1945.

Walker, Marguerite L. Types of maladjusted personality. Sociology and social research, 30:21–26, September–October 1945.

Walsh, Mary Edward (Sister). Saint Vincent de Paul—Saint Louise de Marillac and their daughters. Their care of the insane. American journal of psychiatry, 102:198–201, September 1945.

Wechsler, David and Hartogs, Renatus. The clinical measurement of anxiety; an experimental approach. Psychiatric quarterly, 19:618–35, October 1945.

Weiss, Edward, M.D. Psychosomatic problems in fertility. Human fertility, 10:74–78, September 1945.

Wender, Louis, M.D. Psychiatry in the war and in the post-war era. Herald, Wender welfare league, 11: 4–5, October 1945.

Whiles, William H. A study of neurosis among repatriated prisoners of war. British medical journal (London), p. 697–98, November 17, 1945.

White, Alice M. Predicting your baby's future: even in very young children certain types of temperament and body build seem to go along together. Parents' magazine, 20:16–17, 82, 84, 86, October 1945.

Whitebook, Oscar E. The professional confidence in the case work relationship. Family 26:250–57, November 1945.

Whitehorn, John C., M.D. Constructive factors in the personality. Proceedings of the Royal society of medicine, Section of psychiatry (London), 38:683–84, October 1945.

Wilensky, Dora. War's impact on family life. Canadian welfare (Ottawa), 21:8–16, October 15, 1945.

Wittson, Cecil L., M.D. and Hunt, W. A. Psychiatric selection at the pre-commissioning level. U. S. naval medical bulletin, 45:621–27, October 1945.

Witty, Paul A. New evidence on the learning ability of the Negro. Journal of abnormal and social psychology, 40:401–4, October 1945.

Wolberg, Lewis R., M.D. A mechanism of hysteria elucidated during hypnoanalysis. Psychoanalytic quarterly, 14:528–34, October 1945.

Wolf, Anna W. M. Discipline or what have you? Parents' magazine, 20: 16–17, 145–49, November 1945.

Yannet, Herman, M.D. Diagnostic classification of patients with mental deficiency: distribution of 1,330 institutionalized patients, with review of incidence of convulsive disorders and noncerebral developmental anomalies. American journal of diseases of children, 70:83–88, August 1945.

Zangwill, O. L. A review of psychological work at the Brain injuries unit, Edinburgh, 1941–5. British medical journal (London), p. 248–51, August 25, 1945.

STATE MENTAL-HYGIENE ORGANIZATIONS

Alabama Society for Mental Hygiene. Miss Catherine Vickery, Secretary. C/o Alabama College, Montevallo, Ala.

Arizona Society for Mental Hygiene. Rev. A. L. Krohn, President. 318 W. Granada, Phoenix, Ariz.

Northern California Society for Mental Hygiene. Mr. Jack Spear, Executive Secretary. 45 Second Steet, San Francisco, Calif.

Southern California Society for Mental Hygiene. Miss Janet Nolan, Executive Director. 117 West 9th Street, Los Angeles 15, Calif.

Connecticut Society for Mental Hygiene. Miss Frances Hartshorne, Executive Secretary. 152 Temple Street, New Haven, Conn.

Delaware Society for Mental Hygiene. Miss Emily O'Malley, Acting Director. 1308 Delaware Avenue, Wilmington, Del.

Illinois Society for Mental Hygiene. Dr. Rudolph G. Novick, Medical Director. 343 S. Dearborn Street, Chicago 4, Ill.

Iowa State Society for Mental Hygiene. Dr. Norman D. Render, Executive Director. 1026 Des Moines Street, Des Moines, Iowa.

Kentucky Mental Hygiene Association. Mrs. Ella Layne Brown, Executive Secretary. 9 Euclid Avenue, Winchester, Ky.

Louisiana Committee for Mental Health. Mrs. Philip J. Bayon, Executive Secretary. 816 Hibernia Bank Building, New Orleans 12, La.

Maine Teachers Mental Hygiene Association. Dr. Charles A. Dickinson, Secretary. University of Maine, Orono, Me.

Maryland Mental Hygiene Society. Dr. Ralph P. Truitt, Executive Secretary. 601 W. Lombard Street, Baltimore 1, Md.

Massachusetts Society for Mental Hygiene. Miss Bernice Henderson, Executive Secretary. 3 Joy Street, Boston, Mass.

Michigan Society for Mental Hygiene. Mr. Harold G. Webster, Executive Secretary. 514 Francis Palms Building, Detroit 1, Mich.

Minnesota Mental Hygiene Society. Mrs. Carl Lefevre, Executive Secretary. C/o Dight Institute, University of Minnesota, Minneapolis 14, Minn.

Missouri Association for Mental Hygiene. Mrs. Elizabeth Lingenfelter, Secretary. 1020 McGee Street, Kansas City, Mo.

New York State Committee on Mental Hygiene of the State Charities Aid Association. Miss Katharine G. Ecob, Executive Secretary. 105 East 22nd Street, New York, N. Y.

North Carolina Mental Hygiene Society. Dr. Maurice Greenhill, Secretary. C/o Duke Hospital, Durham, N. C.

Ohio Mental Hygiene Association. 1100–04 Schofield Building, Cleveland, Ohio.

Oregon Mental Hygiene Society. Miss June J. Joslyn, Executive Secretary. Platt Building, 519 West Park, Portland 5, Ore.

Pennsylvania—Mental Hygiene and Public Health Division, Public Charities Association of Pennsylvania. Dr. Arthur H. Estabrook, Secretary. 311 S. Juniper Street, Philadelphia, Pa.

Rhode Island Society for Mental Hygiene. Dr. Temple Burling, Medical Director. 100 North Main Street, Providence, R. I.

South Carolina Society for Mental Hygiene. Rev. J. Obert Kempson, President. Drawer 189, Columbia, S. C.

Texas Society for Mental Hygiene. Miss Lillian Snyder, Secretary. John Sealy Hospital, Galveston, Tex.

Utah Society for Mental Hygiene. Miss Mary Storey, Secretary. 105 Belvedere Apt. Hotel, Salt Lake City, Utah.

Vermont Society for Mental Hygiene. Miss Dorothy Smithson, Secretary. 79 Center Street, Rutland, Vt.

Virginia Mental Hygiene Society. Mr. Frank W. Gwaltney, Executive Secretary. 309 N. 12th Street, Richmond 19, Va.

Washington Society for Mental Hygiene. Mr. George Ault, Executive Secretary. 408 Seaboard Building, Seattle 1, Wash.

Wisconsin Society for Mental Hygiene. Dr. Esther H. DeWeerdt, Executive Secretary. 405 East Grand Avenue, Beloit, Wis.

Hawaii Territorial Society for Mental Hygiene. Mrs. Dorothy Anthony, Executive Secretary. Mabel L. Smyth Memorial Building, Honolulu, T. H.